



## Chronological Claim Notes:

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>8864540</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b>	<b>Phone (Mobile)</b>		

The notes are sorted by Task Completed Date when the Task Status is Closed, otherwise they are sorted by the Last Update Date of the Task.

### \*\*\*\* Important Notice \*\*\*\*

**This report is for Internal Use Only and contains Protected Health Information (PHI)**

**Internal Aetna Users must adhere to Aetna's Patient Confidentiality standards.**

**For further information please visit: [Aetna's Information Security Statement of Po](#)**

### \*\*\*CONFIDENTIALITY NOTICE\*\*\*

This report, including all information contained herein, is intended only for the use of the party with authorized access and may contain privileged and confidential information. The party with authorized access shall not further distribute the information transmitted herein unless authorized by law or with the express written consent of the subject. (v2)

Run Date: 10/06/2015 6:45:01 am

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Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
AddTimeToExistingLOAClaim	10/4/13	Closed	10/4/13 5:27 pm	TERESA CRESPO	MOHINEE VELIAN	MOHINEE VELIAN	10/4/13 5:31 pm

Intake Method: Telephonic

This leave request is: Intermittent

Is or will the leave be more than 3 consecutive days? No

Is the leave the result of a non work related accident? No

Was or will inpatient or outpatient hospitalization occur as a result of condition? No

What new day(s) would you like to report? 09/09/2013|09/19/2013|09/27/2013|10/07/2013

Enter absence from and to times for each of the absences being reported at the time: 09/09/2013|false|8\$00\*17\$00^09/19/2013|false|8\$00\*17\$00^09/27/2013|false|8\$00\*17\$00^10/07/2013|false|8\$00\*10\$00

If you would like to have a Short Term Disability claim created, please select 'Yes' below. If you do not want to have a Short Term Disability claim created, please select 'No.' No

EE Initiate Claim	10/4/13	Closed	10/4/13 9:46 am	ALEX LOZOYA	ALEX LOZOYA	ALEX LOZOYA	10/4/13 9:46 am
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Intake Method: Telephonic

Home E-Mail Address

Alternative Contact Number:

Cell Phone Number:

Do you plan to receive any communications at a temporary address or phone number during your leave? No

What is the reason for the leave? Employee's own illness

This leave request is: Intermittent

Is or will the leave be more than 3 consecutive days? No

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Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

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Is the leave the result of an accident?	Unknown
Are you scheduled for or have you had a procedure for this condition?	Unknown
Do you consider your disability work related?	No
Are you currently working?	Yes
What is or will be your first full day of absence?	10/04/2013
Unknown	No
Was or will this absence be a full or partial day/shift? (if the first day of absence is unknown, select full)	Partial
What hours are you reporting for this requested absence:	10/04/2013 0 8\$00*10\$00
What is or was your weekly work schedule for your requested absence:	09/28/2013 1 0\$*0\$ false^09/29/2013 1 0\$*0\$ false^09/30/2013 0 8\$00*17\$00 false^10/01/2013 0 8\$00*17\$00 false^10/02/2013 0 8\$00*17\$00 false^10/03/2013 0 8\$00*17\$00 false^10/04/2013 0 8\$00*17\$00 false^10/05/2013 1 0\$*0\$ false
Have you informed your employer of your need for a leave?	No
Are you employed elsewhere?	No
Company Name:	
Address Line1:	
Address Line2:	
Address Line3:	
City:	
State:	
Zip:	
Country:	
Days/Hours Worked:	
Work Schedule:	

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Are you currently receiving other STD, LTD Workers Compensation or any other  
benefits?

If yes, what is the name of the carrier who administers that benefit?

Unknown

No

Other Income:

If other, specify:

Frequency of Payment:

Amount:

Start Date:

Thru Date:

Have you seen a Health Care Provider about this condition?

Yes

Health Care Provider Last Name:

Health Care Provider First Name:

Health Care Provider Address 1:

Health Care Provider Address 2:

Health Care Provider City:

Health Care Provider State/Province:

Health Care Provider Zip:

Health Care Provider Phone #:

Health Care Provider Fax #:

What is the treating Health Care Provider's specialty?

If Other, please define:

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When was your last office visit?

When is your next office visit?

Health Care Provider Last Name:

Health Care Provider First Name:

Health Care Provider Address 1:

Health Care Provider Address 2:

Health Care Provider City:

Health Care Provider State/Province:

Health Care Provider Zip:

Health Care Provider Phone #:

Health Care Provider Fax #:

What is the treating Health Care Provider's specialty?

What is your primary medical condition that keeps you from working?

Other

If Other, please define:

Detached tendons In both Shoulders

Provide a description of the symptoms:

STD

No

Statutory

No

Description of Job Activities:

sitting and typing

Place a check mark in all the boxes that identify any diagnostic test that has been completed for this condition:

MRI

If Other, please define:

Name:

If Other, please define:

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Dosage:

Frequency:

Every

As Needed

In order for us to accurately estimate the length of time it could take for you to 19015|19005  
return to work, it is important to understand your medical history.

Place a check mark in all the boxes below that identify medical conditions.

If Other, please define:

It is sometimes necessary to leave a detailed message in the event that you Yes  
cannot be reached. May we leave a detailed message that may include specifi  
information regarding your condition?

To ensure that we are always speaking to the right person when discussing Yes  
personal confidential information, will you provide us with either your mother's  
maiden name or a 4-digit pin that we can use for security purposes?

If Yes:

Which would you like to provide us?

4-digit Pin

Information provided:

1125

Are you familiar with your rights under FMLA?

Yes

Are you familiar with how Aetna administers FMLA for your company?

No

Type of Leave

Amount of Time (Hours)

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Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Enter additional comments that may help support your claim:

Caller ID:954-693-2000  
 8254-016  
 Sup:Susan Park  
 214-797-6488  
 Name:Arthur Davis  
 DOB:REDACTED  
 Phone :REDACTED  
 Reason for Call: Detached tendons In Shoulders  
 Side of Body:both

Thank you for calling Aetna:

Quick Day(s)	10/7/13	Closed	10/7/13 5:10 pm	TERESA CRESPO	BAMBI JEREMICZ	BAMBI JEREMICZ	10/7/13 5:10 pm
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What new day(s) are you requesting for your existing Intermittent leave? 10/08/2013|10/09/2013|10/10/2013|10/11/2013

Dates and Times:

Initial Triage Review	10/4/13	Closed	10/7/13 12:04 pm	TERESA CRESPO	ALEX LOZOYA	TERESA CRESPO	10/7/13 12:04 pm
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Eligibility verification with employer:

No

Standalone Cert on File

Total Hours Worked in year prior to first day of absence:

1746

Length of Service as of first day of absence:

88.5 months

LOA Benefit Eligibility

Transaction Status:

<TABLE><TR><TD>Federal Family and Medical Leave Act (FMLA):</TD><TD>Pend/Awaiting certification</TD></TR></TABLE>

STD

No

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OLA	No
W/C	No
MLOA	No
LOA	No
PFL	No

LOA Benefit Accumulation:

To Link this Leave to an already existing Leave, select Leave to be linked to frc the grid:

To inherit eligibility from a previous leave, select the leave from the grid:

Select Explosion:

Conditional Approval Explosion

Send preliminary designation letters

Yes

Comments:

doh 5/22/06  
Hours worked: 1726.8  
Eligibility verification with ER: no  
Reason for request: eoi  
Intermittent or Continuous: I  
DX: Detached tendons In both Shoulders  
FDA: 10/4/13  
PRTW:  
FMLA weeks used: unknown  
FMLA weeks available: assumed 12 wks  
State Leave Eligible: n

To Address List:

US\_leave\_administrator@dell.com;STD\_LOA@aetna.com,SUSAN\_PARKER@DELL.COM,

CC Adress List:

Email Address Modified by User:

No

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Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
EE - Prelim Designation	10/7/13	Closed	10/7/13 12:04 pm	TERESA CRESPO	TERESA CRESPO	TERESA CRESPO	10/7/13 12:04 pm

Mailing Method:

Do Not Send

Comments:

Minimum Billable Hours:

BHU Billable Hours:

Maximum Billable Hours :

FMLA Absence Adjudication	10/4/13	Closed	10/7/13 12:05 pm	TERESA CRESPO	MOHINEE VELIAN	TERESA CRESPO	10/7/13 12:05 pm
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Comments:

pending awaiting for deter

AddTimeToExistingLOAClaim	10/10/13	Closed	10/10/13 10:55 am	TERESA CRESPO	TERESA CRESPO	TERESA CRESPO	10/10/13 10:56 am
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Intake Method

Telephonic

This leave request is:

Continuous

Is or will the leave be more than 3 consecutive days?

Yes

Is the leave the result of a non work related accident?

Unknown

Was or will inpatient or outpatient hospitalization occur as a result of condition?

Unknown

What is your First Day Absence?

10/14/2013

Was or will this absence be a full or partial day/shift?

Full

Have you already return to work?

No

When do you plan to return to work?

11/11/2013

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If you would like to have a Short Term Disability claim created, please select 'Yes' below. If you do not want to have a Short Term Disability claim created, please select 'No.'

Do you have your health insurance through Aetna? Unknown

Who is the Health Insurance Carrier?

If Other:

Comments

FMLA Absence Adjudication	10/7/13	Closed	10/10/13 10:57 am	AKINKAWON TURNER	BAMBI JEREMICZ	TERESA CRESPO	10/10/13 10:57 a
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Comments: pending awaiting for deter

FMLA Absence Adjudication	10/10/13	Closed	10/10/13 10:57 am	AKINKAWON TURNER	TERESA CRESPO	TERESA CRESPO	10/10/13 10:57 a
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Comments: pending awaiting for deter

Email Response to Member	10/17/13	Closed	10/17/13 5:18 pm	KENNETH WOOLFORK	KENNETH WOOLFORK	KENNETH WOOLFORK	10/17/13 5:18 p
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To Address List: REDACTED

CC Address List:

Do Not Send No

Comments:

Email From Member	10/17/13	Closed	10/17/13 5:19 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	KENNETH WOOLFORK	10/17/13 5:19 p
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Member Home Email Address REDACTED

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Date and Time Submitted	10/17/2013 12:47:57 PM
Question Category selected	My Claim
Question Submitted	Good morning is there anything I need to do?
Plan of Action	Email response to Member
	Dear MR. ARTHUR DAVIS,
	Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Leave #: 8864540.
	A Short Term Disability introductory letter was mailed to you on October 11, 2013. Please follow the instructions in this letter and have the Authorization to Share and Use Medical Information form and the FML Certification form completed and returned to Aetna in a timely manner.
	Your letters and forms are also available for you to view on our website. You may log into your claim and click on the VIEW MY LETTERS tab; then click on the desired letter. Please be sure to disable any pop up blockers on your computer as the letter will open as a pop up.
	Please let us know if we can provide additional assistance.
Inquiry Analysis:	Claim management process
Details of Inquiry:	
Response Analysis:	Customer Service response
Details of Response:	
Response Method:	Reply via email

FMLA Determination	10/30/13 Closed	10/17/13 10:09 pm	AKINKAWON TURNER	TERESA CRESPO	AKINKAWON TURNER	10/17/13 10:09 p
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Comments:

Cert Status: Accepted/STD  
 Cert Period Start Date: 10/9/2013 12:00:00 AM  
 Cert Period End Date: 11/24/2013 12:00:00 AM  
 Cert Period Term Date: 11/24/2013 12:00:00 AM

If you wish to schedule one of the following tasks, please select the applicable button to the right:

Integrated / Extension Approved	12/5/13	Closed	12/5/13 1:39 pm	AKINKAWON TURNER	AKINKAWON TURNER	AKINKAWON TURNER	12/5/13 1:39 pm
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Notes: Claim #8893435 Approval extended through 12/13/2013

Auto Approval Fail	12/5/13	Closed	12/5/13 1:40 pm	AKINKAWON TURNER	WKAB SYSTEM	AKINKAWON TURNER	12/5/13 1:40 pm
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#### Audit information

The following dates for Federal Family and Medical Leave Act (FMLA) failed to be auto approved via the auto approval process on 12/5/2013 11:33:09 AM: 9/9/2013 7:00:00 AM - 9/9/2013 4:00:00 PM These dates failed for the following reason: Dates were not within the Cert Approved and Cert Time timeframe.

The following dates for Federal Family and Medical Leave Act (FMLA) failed to be auto approved via the auto approval process on 12/5/2013 11:33:09 AM: 9/20/2013 7:00:00 AM - 9/26/2013 4:00:00 PM These dates failed for the following reason: Dates were not within the Cert Approved and Cert Time timeframe.

The following dates for Federal Family and Medical Leave Act (FMLA) failed to be auto approved via the auto approval process on 12/5/2013 11:33:09 AM: 9/30/2013 7:00:00 AM - 10/3/2013 4:00:00 PM These dates failed for the following reason: Dates were not within the Cert Approved and Cert Time timeframe.

The following dates for Federal Family and Medical Leave Act (FMLA) failed to be auto approved via the auto approval process on 12/5/2013 11:33:10 AM: 9/19/2013 7:00:00 AM - 9/19/2013 4:00:00 PM These dates failed for the following reason: Dates were not within the Cert Approved and Cert Time timeframe.

The following dates for Federal Family and Medical Leave Act (FMLA) failed to be auto approved via the auto approval process on 12/5/2013 11:33:10 AM: 9/27/2013 7:00:00 AM - 9/27/2013 4:00:00 PM These dates failed for the following reason: Dates were not within the Cert Approved and Cert Time timeframe.

The following dates for Federal Family and Medical Leave Act (FMLA) failed to be auto approved via the auto approval process on 12/5/2013 11:33:10 AM: 10/4/2013 7:00:00 AM - 10/4/2013 9:00:00 AM These dates failed for the following reason: Dates were not within the Cert Approved and Cert Time timeframe.

The following dates for Federal Family and Medical Leave Act (FMLA) failed to be auto approved via the auto approval process on 12/5/2013 11:33:10 AM: 10/7/2013 7:00:00 AM - 10/7/2013 9:00:00 AM These dates failed for the following reason: Dates were not within the Cert Approved and Cert Time timeframe.

The following dates for Federal Family and Medical Leave Act (FMLA) failed to be auto approved via the auto approval process on 12/5/2013 11:33:11 AM: 10/8/2013 7:00:00 AM - 10/8/2013 4:00:00 PM These dates failed for the following reason: Dates were not within the Cert Approved and Cert Time timeframe.

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>8864540</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Integrated / Extension Approved	1/9/14	Closed	1/21/14 4:16 pm	AKINKAWON TURNER	AKINKAWON TURNER	AKINKAWON TURNER	1/21/14 4:16 pm
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Notes: Claim #8893435 Approval extended through 1/12/2014

EE - 100% Exhaustion Ltr	1/9/14	Closed	1/21/14 9:39 am	AKINKAWON TURNER	WKAB SYSTEM	AKINKAWON TURNER	1/21/14 9:39 am
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Mailing Method: USPS

Do Not Send No

Comments:

Email From Member	1/23/14	Closed	1/24/14 8:23 am	NA REGIONAL CALL CENTER EMAIL_QUEUE_USER_1	WKAB SYSTEM	DOMINICA TAYLOR	1/24/14 8:23 am
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Member Home Email Address **REDACTED**

Date and Time Submitted 1/23/2014 8:24:07 PM

Question Category selected My Claim

Question Submitted Good afternoon, what is needed to certify claim through January 31st when I am having my scheduled surgery.

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>8864540</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action

email response

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 8893435.

Your Short Term Disability claim is currently approved through 01/12/2014. We have advised your Claim Manager of your update. In order to extend your claim, we need your doctor to provide updated medical information. Please have your doctor fax office visit notes from your last office visit. Once this information has been received and reviewed, your Claim Manager will contact you.

Inquiry Analysis:

Please let us know if we can provide additional assistance.

Details of Inquiry:

Claim management process

Response Analysis:

Customer Service response

Details of Response:

Response Method:

Reply via email

Integrated / Extension Approved	1/30/14	Closed	1/30/14 3:26 pm	AKINKAWON TURNER	AKINKAWON TURNER	AKINKAWON TURNER	1/30/14 3:26 pm
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Notes:

Claim #8893435 Approval extended through 1/31/2014

EE Employment Status	2/18/14	Closed	2/18/14 10:38 am	AKINKAWON TURNER	LoadManager	AKINKAWON TURNER	2/18/14 10:38 am
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Audit information

The client submitted notice of terminated status, please review all open or pended claims.

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>8864540</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Employment Status Change Notification	2/17/14	Closed	2/18/14 12:09 pm	AKINKAWON TURNER	LoadManager	AKINKAWON TURNER	2/18/14 12:09 pm
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Employment Status:

Employment Status Effective Date:

Integrated / Extension Approved	2/18/14	Closed	2/18/14 12:27 pm	AKINKAWON TURNER	AKINKAWON TURNER	AKINKAWON TURNER	2/18/14 12:27 pm
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Notes:

Claim #8893435 Approval extended through 3/11/2014

RTW Follow-Up	2/14/14	Closed	3/5/14 10:06 am	AKINKAWON TURNER	AKINKAWON TURNER	AKINKAWON TURNER	3/5/14 10:06 am
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Comments

exhausted

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>8864540</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

<b>Task Name &amp; Task Details:</b>	<b>Scheduled Date</b>	<b>Task Status</b>	<b>Completed Date</b>	<b>Claim Owner</b>	<b>Originator</b>	<b>Last Updated By</b>	<b>Date Last Updated</b>
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### Notes Trending by Claim Status

	Total	Closed
<b>Total</b>	22	22
Integrated / Extension Approved	4	4
FMLA Absence Adjudication	3	3
AddTimeToExistingLOAClaim	2	2
Email From Member	2	2
Auto Approval Fail	1	1
EE - 100% Exhaustion Ltr	1	1
EE - Prelim Designation	1	1
EE Employment Status	1	1
EE Initiate Claim	1	1
Email Response to Member	1	1
Employment Status Change Notification	1	1
FMLA Determination	1	1
Initial Triage Review	1	1

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>8864540</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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	Total	Closed
Quick Day(s)	1	1
RTW Follow-Up	1	1

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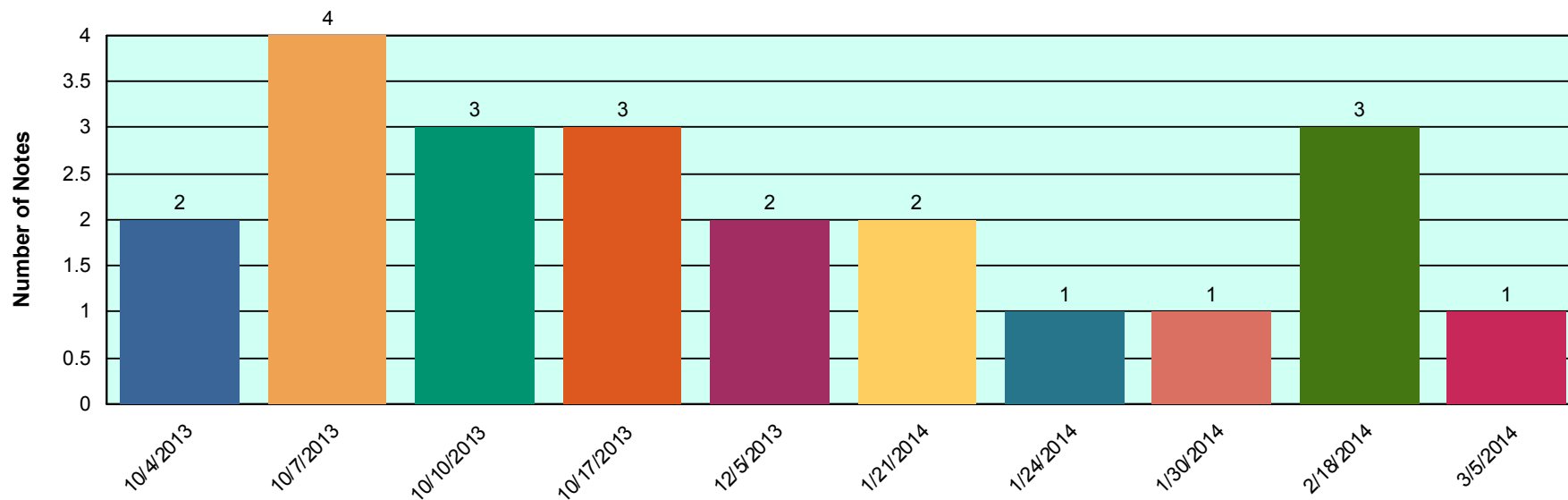
Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>8864540</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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## Note Summary

Number of Notes Updated by Date



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Report Date: 10/06/2015

Client Name: Dell Inc

(Less Info)

IHD Consent Effective: N/A

Date of Birth: REDACTED

Age: 52

Gender: Male

Preferred Contact#: REDACTED Phone (Mobile)

Providers

Rehab Vendors

Alerts

Contacts

Active Member Alerts

Submit Action

Create Date	Claim ID	Alert Name	Notification	Created By	Action
▼ 06/01/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	RAJESH KUMAR	Please Select ▼
▼ 05/29/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	ANKESH KUMAR	Please Select ▼
▼ 05/27/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	NAVTEJ BHADUR	Please Select ▼
▼ 04/28/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	JASEEM ANSARI	Please Select ▼
▼ 04/28/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	JASEEM ANSARI	Please Select ▼
▼ 02/09/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	PAVAN KUMAR	Please Select ▼
▼ 01/14/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	BHUPENDRA SINGH	Please Select ▼
▼ 01/08/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	ARUN CHAWLA	Please Select ▼
▼ 12/26/2014	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	ROHIT SINGH	Please Select ▼
▼ 09/29/2014	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	YADAV VIKAS	Please Select ▼

Alerts And Notification History

Expand All Details		View All		Show All Notes		<< < 1 2 3 4 5 of 5 > >>	
Create Date	Claim ID	Alert Name	Notification (Y/N)	Created By	Dismiss Date		
▼ 04/30/2015	9452367	Aetna received information regarding your claim	Not Being Sent	RAJESH KUMAR	05/03/2015		
▼ 04/03/2015	9452367	Aetna received information regarding your claim	Not Being Sent	KAPIL SINGH	04/18/2015		
▼ 03/20/2015	9452367	Aetna received information regarding your claim	Not Being Sent	DASHRAT SINGHBIST	04/18/2015		
▼ 03/09/2015	9452367	Aetna received information regarding your claim	Not Being Sent	BHUPENDRA SINGH	03/15/2015		
▼ 02/09/2015	9452367	Aetna received information regarding your claim	Not Being Sent	WEB SERVICE	02/17/2015		
▼ 02/09/2015	9452367	Aetna received information regarding your claim	Not Being Sent	WEB SERVICE	02/17/2015		



▼ 01/30/2015	9452367	Authorization to Request Health Information	Not Being Sent	CANDICE HOY	02/09/2015
▼ 01/30/2015	9452367	Disability Appeal Request Form	Not Being Sent	CANDICE HOY	02/09/2015
▼ 01/29/2015	9452367	Aetna received information regarding your claim	Not Being Sent	YADAV VIKAS	02/17/2015
▼ 01/13/2015	9452367	Aetna has issued a payment	Not Being Sent	WKAB SYSTEM	02/17/2015

(Less Info)  
Client Name: Dell Inc  
IHD Consent Effective: N/A

Date of Birth: REDACTED  
Age: 52  
Gender: Male  
Preferred Contact#: REDACTED Phone (Mobile)

Providers  
Rehab Vendors

Alerts

Contacts

▲ Manage Notes: ADD NEW




Subject		Create Date	Creator	Title	Claim #	Contact
* Claim Status	▼	10/6/2015 6:51:56 AM	PRAKASH PRASAD	PARALEGAL II	8864540 (LOA-C) Closed	* Employee ▼

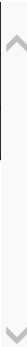
Topic:\*

Save See Reminders Cancel

▲ Follow Up Required

Task Name	Schedule Date	Assign Owner	Memo
-----------	---------------	--------------	------

<input type="checkbox"/> Late Employee Contact	10/06/2015		TURNER,AKINKAWON	Select	
<input type="checkbox"/> Late Employer Contact	10/06/2015		TURNER,AKINKAWON	Select	
<input type="checkbox"/> Late Provider Contact	10/06/2015		TURNER,AKINKAWON	Select	



Save & Create task

Contact Notes History

Expand All Details

View 

Claim : 8864540

Contact Filter 

All

Subject Filter 

All

Show 

10

 Notes

Subject	Last Update Date	Creator	Title	Claim #	Contact
▼ Claim Status	10/10/2013 10:55:36 AM	TERESA CRESPO	STD / LOA BENEFIT MANAGER	8864540 (LOA-C) Closed	Other
Topic: ee requesting add std to loa					
▼ Claim Status	10/10/2013 10:53:51 AM	ANASTASIA SNOOK	CUSTOMER SRVC REPRESENTATIVE	8864540 (LOA-C) Closed	Employee
Topic: EE SX date					
▼ Claim Status	10/8/2013 4:17:12 PM	SHARLYNN DARRIS	CUSTOMER SRVC REPRESENTATIVE	8864540 (LOA-C) Closed	Employee
Topic: ee requesting add std to loa					
▼ Claim Status	10/8/2013 4:07:39 PM	BAMBI JEREMICZ	CUSTOMER SRVC REPRESENTATIVE	8864540 (LOA-C) Closed	Employee
Topic: New Claim					
▼ Claim Status	10/7/2013 5:12:20 PM	BAMBI JEREMICZ	CUSTOMER SRVC REPRESENTATIVE	8864540 (LOA-C) Closed	Employee
Topic: EE calling in surgery information					
▼ Claim Status	10/7/2013 12:05:17 PM	TERESA CRESPO	STD / LOA BENEFIT MANAGER	8864540 (LOA-C) Closed	Other
Topic: EE REPORTED 09/09, 09/19, 09/27 AND 10/07 FROM 07AM-09AM AND 10/07 FROM 02PM-04PM					
▼ Claim Status	10/4/2013 5:31:11 PM	MOHINEE VELIAN	CUSTOMER SERVICE REPRESENTATIVE	8864540 (LOA-C) Closed	Employee
Topic: EE REPORTED 09/09 , 09/19, 09/27 AND 10/07 FROM 07AM-09AM AND 10/07 FROM 02PM-04PM					

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : CLAIM

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	10/10/2013 10:55:36AM	TERESA CRESPO	STD / LOA BENEFIT MANAGER	8864540	Other

Topic: ee requesting add std to loa  
acknwldg, open a std claim

Claim Status	10/10/2013 10:53:51AM	ANASTASIA SNOOK	CUSTOMER SRVC REPRESENTATIVE	8864540	Employee
--------------	-----------------------	-----------------	------------------------------	---------	----------

Topic: EE SX date  
TCF EE to advise his SX is 10/11. EE advised he has not recv'd anything in the mail, CSR advised need HCPC to approve the claim. EE advised need STD claim opened, thought did yesterday. CSR advised not STD open, only FMLA intermittent. CSR transferred EE to Intake to open STD claim.

Claim Status	10/8/2013 4:17:12PM	SHARLYNN DARRIS	CUSTOMER SRVC REPRESENTATIVE	8864540	Employee
--------------	---------------------	-----------------	------------------------------	---------	----------

Topic: ee requesting add std to loa  
ee is having surgery for same condition as existing intermitten loa claim.  
please change status from intermitten to continuoius and add std  
FDA: 10/9/  
LDW: 10/8  
\*\*GAP: intermitten loa claim 10/9- 11/11  
RTW: 4 weeks 11/11/13, then start therapy  
Hospital: Premier Orthopaedics @ 615-332-3600  
Dr: james renfro @ 394 harding place nashville tenn 37211

Claim Status	10/8/2013 4:07:39PM	BAMBI JEREMICZ	CUSTOMER SRVC REPRESENTATIVE	8864540	Employee
--------------	---------------------	----------------	------------------------------	---------	----------

Topic: New Claim  
New Claim Transferred ee to Intake.

Claim Status	10/7/2013 5:12:20PM	BAMBI JEREMICZ	CUSTOMER SRVC REPRESENTATIVE	8864540	Employee
--------------	---------------------	----------------	------------------------------	---------	----------

Topic: EE calling in surgery information  
EE called to advise he will be having out patient surgery on 10/11/2013 at Premier Orthopedics. Advise ee to call and confirm on 10/10/2013 that he is still having his surgery so we can follow up for any additional information that may be needed. EE also called in days out from 10/8/2013 ,10/09/2013,10/10/2013 and 10/11/2013 all full days. Transaction Number 8877357

Claim Status	10/7/2013 12:05:17PM	TERESA CRESPO	STD / LOA BENEFIT MANAGER	8864540	Other
--------------	----------------------	---------------	---------------------------	---------	-------

Topic: EE REPORTED 09/09, 09/19, 09/27 AND 10/07 FROM 07AM-09AM AND 10/07 FROM 02PM-04PM  
acknwldg

Claim Status	10/4/2013 5:31:11PM	MOHINEE VELIAN	USTOMER SERVICE REPRESENATIV	8864540	Employee
--------------	---------------------	----------------	------------------------------	---------	----------

Topic: EE REPORTED 09/09 , 09/19, 09/27 AND 10/07 FROM 07AM-09AM AND 10/07 FROM 02PM-04PM  
EE REPORTED 09/09. 09/19 AND 09/27 AND 10/07 FROM 07AM-09AM AND 10/07 FROM 2PM-04PM

Client Name: Dell Inc

(Less Info)  
IHD Consent Effective: N/A

Date of Birth: REDACTED

Age: 52

Gender: Male

Preferred Contact#: REDACTED Phone (Mobile)

Providers

Rehab Vendors

Alerts

Contacts

Active Member Alerts

Submit Action

Create Date	Claim ID	Alert Name	Notification	Created By	Action
▼ 06/01/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	RAJESH KUMAR	Please Select ▼
▼ 05/29/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	ANKESH KUMAR	Please Select ▼
▼ 05/27/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	NAVTEJ BHADUR	Please Select ▼
▼ 04/28/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	JASEEM ANSARI	Please Select ▼
▼ 04/28/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	JASEEM ANSARI	Please Select ▼
▼ 02/09/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	PAVAN KUMAR	Please Select ▼
▼ 01/14/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	BHUPENDRA SINGH	Please Select ▼
▼ 01/08/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	ARUN CHAWLA	Please Select ▼
▼ 12/26/2014	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	ROHIT SINGH	Please Select ▼
▼ 09/29/2014	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	YADAV VIKAS	Please Select ▼

Alerts And Notification History

Expand All Details

View

All

Show 10 Notes

<< < 1 2 3 4 5 of 5 > >>

Create Date	Claim ID	Alert Name	Notification (Y/N)	Created By	Dismiss Date
▼ 04/30/2015	9452367	Aetna received information regarding your claim	Not Being Sent	RAJESH KUMAR	05/03/2015
▼ 04/03/2015	9452367	Aetna received information regarding your claim	Not Being Sent	KAPIL SINGH	04/18/2015
▼ 03/20/2015	9452367	Aetna received information regarding your claim	Not Being Sent	DASHRAT SINGHBIST	04/18/2015
▼ 03/09/2015	9452367	Aetna received information regarding your claim	Not Being Sent	BHUPENDRA SINGH	03/15/2015
▼ 02/09/2015	9452367	Aetna received information regarding your claim	Not Being Sent	WEB SERVICE	02/17/2015
▼ 02/09/2015	9452367	Aetna received information regarding your claim	Not Being Sent	WEB SERVICE	02/17/2015
▼ 01/30/2015	9452367	Authorization to Request Health Information	Not Being Sent	CANDICE HOY	02/09/2015

▼ 01/30/2015	9452367	Disability Appeal Request Form	Not Being Sent	CANDICE HOY	02/09/2015
▼ 01/29/2015	9452367	Aetna received information regarding your claim	Not Being Sent	YADAV VIKAS	02/17/2015
▼ 01/13/2015	9452367	Aetna has issued a payment	Not Being Sent	WKAB SYSTEM	02/17/2015

Client Name: Dell Inc

(Less Info)  
IHD Consent Effective: N/A

Date of Birth: REDACTED

Age: 52

Gender: Male

Preferred Contact#: REDACTED Phone (Mobile)

Providers

Rehab Vendors

Alerts

Contacts

▲ Manage Notes: ADD NEW

Subject		Create Date	Creator	Title	Claim #	Contact
* Claim Status	▼	10/6/2015 5:04:13 AM	PRAKASH PRASAD	PARALEGAL II	EMPLOYEE	* Employee ▼

Topic:\*

Save See Reminders Cancel

▲ Follow Up Required

Task Name	Schedule Date	Assign Owner	Memo
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<input type="checkbox"/> Action Required	10/06/2015		PRASAD,PRAKASH	Select	
<input type="checkbox"/> Complaint Follow Up Required	10/06/2015		PRASAD,PRAKASH	Select	
<input type="checkbox"/> Email Provider Forms	10/06/2015		PRASAD,PRAKASH	Select	
<input type="checkbox"/> Email Supplemental Forms	10/06/2015		PRASAD,PRAKASH	Select	
<input type="checkbox"/> Employee Contact	10/06/2015		PRASAD,PRAKASH	Select	
<input type="checkbox"/> Employer Contact	10/06/2015		PRASAD,PRAKASH	Select	
<input type="checkbox"/> Faxed Form Request APS/BHCS	10/06/2015		PRASAD,PRAKASH	Select	

Save & Create task

## Contact Notes History

Expand All Details

View 

All

Contact Filter 

All

Subject Filter 

All

Show 

10

 Notes

<< < 1 2 3 4 5 of 15 > >>

Subject	Last Update Date	Creator	Title	Claim #	Contact
▼ Appeal	5/28/2015 9:26:22 AM	CHARLAI LANG	Disability Appeals Specialist	9452367 (LTD) Closed	Other
Topic: outgoing call to Atty office					
▼ Claim Status	5/27/2015 11:57:01 AM	PATRICIA HICKEY	Customer Svc Representative	9452367 (LTD) Closed	Other
Topic: speak to appeals analyst					
▼ Appeal	4/24/2015 11:50:48 AM	CHARLAI LANG	Disability Appeals Specialist	9452367 (LTD) Closed	Employee
Topic: outgoing call to ee returning call					
▼ E-mail from Member	4/23/2015 5:01:48 PM	MARIE ANELAS	Customer Svc Representative	9452367 (LTD) Closed	Employee
Topic: e-mail from member-					
▼ E-mail from Member	4/20/2015 6:17:19 PM	MARIE ANELAS	Customer Svc Representative	9452367 (LTD) Closed	Employee
Topic: e-mail from member.					
▼ Appeal	4/20/2015 5:56:34 PM	CHARLAI LANG	Disability Appeals Specialist	9452367 (LTD) Closed	Employee
Topic: call returned					
▼ Appeal	4/20/2015 5:55:09 PM	CHARLAI LANG	Disability Appeals Specialist	9452367 (LTD) Closed	Employee
Topic: outgoing call to ee returning call					
▼ E-mail from Member	4/18/2015 9:34:29 AM	SHERRI MCINNES	Customer Service Rep	9452367 (LTD) Closed	Employee
Topic: update on claim					
▼ Appeal	4/16/2015 4:20:29 PM	CHARLAI LANG	Disability Appeals Specialist	9452367 (LTD) Closed	Employee
Topic: outgoing call to ee returning call					
▼ Claim Status	4/16/2015 1:10:36 PM	SANDRA QUELLA	Customer Svc Representative	9452367 (LTD) Closed	Employee
Topic: TCF EE To check on the status of the claim					



# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
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Topic: outgoing call to Atty office  
spoke with Nikki to leave msg for atty, on A/S vm the atty was requesting re open of the appeal and a copy of the file, Atty indicated that she just got on board to represent ee and A/S advised the file is already closed. The decision ltr went out on 4/23/15 and ee had already requested a copy of the filed on 4/13/15. the Atty does have the option to file suit but we can't open the case again and give more time after it's been closed

Claim Status	05/27/2015 11:57:01AM	PATRICIA HICKEY	Customer Srvc Representative	9452367	Other
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Topic: speak to appeals analyst  
Barbara atty for EE asked to speak to appeals analyst. She was unavailable. Xfrd to vm

authorization form date 4/30 image 17415744

Barbara 615 234 6000  
Cody Allison

Appeal	04/24/2015 11:50:48AM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: outgoing call to ee returning call  
A/S advised that unfortunately the medical documentation did not support ongoing impairment and ltr was mailed today, ee stated he just want a copy of his file with direction on how to file suit. A/S advised that ee would need to take file to any atty who will give ee direction on how to file suit ee thanked A/S

E-mail from Member	04/23/2015 5:01:48PM	MARIE ANELAS	Customer Srvc Representative	9452367	Employee
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Topic: e-mail from member-  
Good morning I spoke to me claims manager this week and was told I would get a decision letter on the 22nd. I do not see a generated letter?

E-mail from Member	04/20/2015 6:17:19PM	MARIE ANELAS	Customer Srvc Representative	9452367	Employee
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Topic: e-mail from member.  
I submitted a request via Document Download. I am submitted here also.  
Appeal Status Appeal Decision Due Date  
Active Upheld 04/22/2015  
Good morning Charlai, I see the decision has been made concerning my appeal. Are there any additional  
Appeal options? If I do not have any appeal options please send me the Denial letter and my Aetna records thank you.  
Arthur Cyril Davis Jr.

Appeal	04/20/2015 5:56:34PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: call returned  
file will be released after decision is finalized

Appeal	04/20/2015 5:55:09PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: outgoing call to ee returning call  
To advise that the decision ltr is under review and A/S will release a copy of the medical file once the ltr is released ee thanked A/S

E-mail from Member	04/18/2015 9:34:29AM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: update on claim  
Good afternoon today I dropped off updated paperwork to the Social security administration. Looking at my timeline, my LTD was approved through Aetna for my shoulder issues. I was out on under doctors care until May 23rd 2014 specifically for my shoulders. Looking at notes from Physical Therapy I was complaining about my shoulders up to the release date. I complained to my surgeon that I was hearing popping and clicking noises but was told it would go away as my shoulders strengthen. 5 months later I was back to his office and two months after I was scheduled for another reattachment. It does not appear that my shoulders healed properly and based on my new surgeons findings, my right shoulder may not return to normal. My left shoulder is still popping and I have occasional pain and I will probably have to have additional surgery on it. How can I be removed from LTD if I never healed? I have been told I cannot work because of my back and the situation is magnified by my shoulder issues.

Appeal	04/16/2015 4:20:29PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: outgoing call to ee returning call  
A/S advised once the final decision is rendered, A/S will have ee's file sent out ee thanked A/S

Claim Status	04/16/2015 1:10:36PM	SANDRA QUELLA	Customer Srvc Representative	9452367	Employee
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Topic: TCF EE To check on the status of the claim  
adv EE that the claim is under review and we will be in contact once a decision has been made, EE ack.

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	04/15/2015 11:37:22AM	NIAJEA LEE	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee

Topic: tcf ee regarding paperwork

ee called to verify if we received his letter requesting his claim file. Informed ee that we received the letter. EE requested to speak to the dbm, tranferred to the dbm vm.

Claim Status	03/24/2015 9:04:00AM	CHANAVIA BROWN	Senior LTD Claim Analyst	9452367	Employee
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Topic: DBM called Ee back

Advised we will need this in writing. He must note of he needs copies of Policies as well, he states he has them. Asked if he needs mailing address or fax number, he states he has all of Shawndra's information. EE thanked me for my call.

E-mail from Member	03/21/2015 6:54:21PM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: request for copy of file

I would like to request a copy of my Aetna Disability file please. Do I have to submit this in writing?

E-mail from Member	03/18/2015 2:22:11PM	MARIE ANELAS	Customer Srvc Representative	9452367	Employee
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Topic: e-mail from member:

Good afternoon, here are the notes from my office visit with Dr. Sean Kaminsky at Pinnacle Surgical Partners in Hermitage TN.

Summary of Today's Visit

Davis , Arthur DOB REDACTED

Account No 324572

Gender: Male

Race: Black or African American

Ethnicity: Not Hispanic or Latino

Preferred Language: English

03/10/2015 visit with Sean B. Kaminsky, MD

Reason for Visit

NP-RTSHLD

Vitals

. Ht 70(in)

. Wt 257 (lbs)

. BMI 36.87 (Index)

. Ht-cm 177.8 (cm)

. Wt-kg 116.57 (kg)

Allergies

. N.K.D.A.

Today's Diagnoses Include

. 719.41 Shoulder Pain, Right

. 727.61 Rotator cuff tear, nontraumatic - Right

Medication List

. Start Percocet : 10-325 MG i tablet as needed Orally every 6 hls, 50

Other medications you are on

. Celebrex:

. Cymbalta :

. Tramadol HC1 :

Notes:

I reviewed the results of the MRI study of the right shoulder from March 2, 2015 revealing a massive tear of the supraspinatus and infraspinatus tendons with retraction of approximately 5 cm and muscular atrophy.

Subscapularis tendinosis present. Subacromial and glenohumeral fluid noted. Biceps tear and synovitis present.

, I reviewed the findings and options for treatment such as medication, injections, living with the symptoms.

activity modification, more time, and finally surgery. Patient did not feel that conservative treatment is worked

for him at all. I also discussed various options for surgery including arthroscopic surgery, latissimus transfer

surgeiv, and shoulder arthroplasty. Risks of surgciv were discussed including hut not

limited to bleeding, infection, nerve, ycin, or artery injury, continuing pain, risks of anesthesia includng loss of

life or limb, heart attack, blood clot, seizure, stroke, failure of any surgcy, need for further surgery, and stiffness.

After having this discussion, the patient wants to proceed with surgery. We have completed the paperwork.

answered all questions, provided prescriptions for medication to use post-operatively, my card, anti information

for the surgery center. I encouraged the patient to call me with ans2 questions or concerns about our discussions

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Appeal	03/17/2015 4:36:32PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee

Topic: outgoing call to ee to determine if the information provided is all the information ee intends to send, ee stated he is in worse shape now then he was when he went out he feels we have all the info needed he is going for surgery and every doctor indicated he can't work so move forward ee is about to apply for welfare because he has no income he can't afford to wait any further

Appeal	03/17/2015 4:30:31PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: ee confirmed surgery date

Appeal	03/17/2015 4:29:09PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: email. received and reviewed MRI received for review

E-mail from Member	03/11/2015 8:24:44PM	DOMINICA TAYLOR	OR CUSTOMER SRVC REPRESENTA	9452367	Employee
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Topic: update  
My surgery is scheduled for March 25th

E-mail from Member	03/11/2015 8:47:53AM	MARIE ANELAS	Customer Svc Representative	9452367	Employee
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Topic: e-mail from member.  
Today I was seen by Dr. Sean Kaminsky MD, he is a Shoulder specialist at Pinnacle Surgical Partners  
5653 Frist Boulevard  
Ste 731  
Nashville, TN 37064  
615-885-2778 Fax 615-986-6052  
Dr Kaminsky confirmed the MRI findings and set recovery expectations. My right shoulder may never fully recovery and I may need shoulder replacement. I am awaiting a call from his office to set a surgery date ASAP and the expected recovery will be many months.

Appeal	03/04/2015 3:23:40PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: EE confirmed that he did receive A/S vm and thanked A/S for the update but he wanted to give A/S an update to advise that he has now re torn his right rotator cuff and possibly his left and more surgery is to be scheduled, ee stated he is not clear if it was with the recent accident or not but he thinks that his body is breaking down and can't take as much as when he was younger. The surgery will be a reattachment which will be a more intense surgery than before. EE states that he was seen by Dr. Renfro his shoulder surgeon, A/S advised that he is on the list to call for clarification so that information should be obtained if the hcp and peer reviewer is able to connect

Claim Status	03/04/2015 3:12:20PM	MOHINEE VELIAN	USTOMER SERVICE REPRESENTIV	9452367	Employee
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Topic: CHARLAI IS CALLING EE BACK  
CHARLAI IS CALLING EE BACK

Appeal	03/04/2015 1:59:46PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: outgoing call to ee A/S left vm in response to email  
A/S advised that ext ltr has been sent out to day, a copy of the plan will be sent as well today, however A/S did not indicate that we left a vm on 1/29/15 we were in receipt of the claim so A/S is sorry if ee took it that it's delayed for this reason. If ee has any further questions to please contact A/S

Appeal	03/04/2015 8:14:32AM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: copy of plan is to be sent to ee overnight

Appeal	03/04/2015 8:13:16AM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: email read and  
A/S to contact ee to clarify the discussion as A/S didn't advise ee that a vm was left on 1/29//15 but that the claim was assigned on that date

E-mail from Member	02/25/2015 5:49:26PM	MARIE ANELAS	Customer Svc Representative	9452367	Employee
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Topic: e-mail from member.  
I would like a copy of my plans Long term Disability documents please. I would like the names and contact information of any party involved with my appeal.

# Central Note System - View All Report

[Click Here To Access The Excel Export View](#)

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
E-mail from Member	02/25/2015 7:55:09AM	MARIE ANELAS	Customer Svc Representative	9452367	Employee

Topic: e-mail from member.

On Feb 20th, I received an email response from Aetna stating "We received the Authorization to Request Protected Health Information, the Disability Appeal Request Form and your medical records for review on 02/09/2015. We will send you a confirmation letter with the details about your claim, once the review has been completed." I was not told anyone had reached out to me, nor did I have any voice messages from Aetna Disability, or Aetna Appeals. Today I received a call from Charlai Lang a Senior LTD Appeals Specialist. The message did not contain her full name or direct contact information. I had to call three different departments to reach her. Ms. Lang is stating she will need an extension on my Appeals process because she tried to contact me on Jan 29th. I do not have a voice message from her, i save all my voice messages from the purchase date of my iPhone. I am struggling to make it and I no longer have any savings. A appeal will push me beyond Dire Straits. I have always contacted Aetna immediately or

Claim Status	02/24/2015 1:43:35PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: outgoing call to ee returning call from vm received

A/S confirmed ee has had another car accident where he was hit from behind again, ee is in therapy and still awaiting a call from the back surgeon's office for a consult, ee states his back is currently locked up and he is not sure it was from slowing down on therapy or the accident, he can't turn to his left or right, they are placing him on muscle relaxers to assist with muscle loosening, ee was using gabapentin and it as helping to reduce his pain and numbness in his leg however ee losing his memory, lost his keys, getting off wrong exits not knowing where he was going to go to places that he frequents, ee also has increased weakness in his right arm and can't type or write for more than a few mins before he feels weakness, ee has not followed up just yet because he was trying to take care of tx for his back and determine if more surgery is needed. EE feels we have everything the test reports shows he has issues with his back and he can't sit or stand for prolonged periods, his doctor has submitted a note reflecting his inability to sit, stand or work, A/S advised that review will be completed and ee will get a ltr requesting additional time so that it can be sent out for peer review and ee's doctors can be contacted, A/S wanted to ensure that prior to completing the review we had everything and ee had not seen the surgeon and a tx plan had been established ee stated he is still waiting for a appt

Claim Status	01/12/2015 12:39:55PM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Contact EE with claim status

DBM contacted EE and informed him that medical information received on 12/23/2014 was insufficient to support ongoing impairment from own occ. DBM informed that claim will be termed as of 1/12/2015. EE inquired that he is still having problems with his back and unable to perform his own occ. DBM informed EE if he disagree with discuss on claim he does have the rights to appeal. EE was informed of his appeals rights.

E-mail from Member	01/07/2015 8:12:29AM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: update on claim

I have been having problems with my right shoulder the past three months.

On December 5th, 2014 I was seen by my Orthopedic Doctor James Renfro. Dr. Renfro took an xray and diagnosed Inflamed AC Joint. Three sessions of PT was suggested, I completed but was still in pain. I received a Cortizone injection in my shoulder on December 26th, 2014. I am still having issues but I am trying to strengthen my shoulder with exercise. I am having extreme pain if I lie on my right shoulder, I cannot lift heavy items and I having shooting pains at times.

Claim Status	12/24/2014 10:23:14AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Acknowledge call

DBM acknowledge call and s/w EE earlier regarding claim status and what is being submitted from treating providers.

E-mail from Member	12/23/2014 4:17:37PM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: update on claim

I just spoke to Dr Yaneyama office they said the have sent information. I was not seen on the dates requested. I was referred to Dr Buechel and my next appointment is in January for Dr Yaneyama. I have asked them to send an update.

Claim Status	12/23/2014 11:25:25AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: RTC to EE

DBM rtc to EE and informed that request from medical records from both his providers were sent out. However, form was received from Dr. Nquist office advising NEW PT's signature. EE informed that he spent the whole mornig yesterday riding to all his treating provider office requesting them to fax over medical records to AETNA. DBM advised that is has not shown up in claim as of yet however, does not mean it hasn't been sent. EE advised that it takes 24- 48 hours to show in claim and once received will call and confirm. EE thanked DBM for calling.

Claim Status	12/18/2014 1:17:35PM	DIANA ACHESON	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: ee sts i sent notes in

ee rcvd letter ee adv would like copy of fax sent to dr Steven Nyquist and any other dr you are req nfo from sent tto the portal so he can take to them he is adv his dr says they have not rcvd anything from aetna please call ee if any questions

Claim Status	12/08/2014 8:18:51AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Acknowledge EE

DBM acknowledge email from EE and no call back is needed.

# Central Note System - View All Report

[Click Here To Access The Excel Export View](#)

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
E-mail from Member	12/05/2014 6:59:59PM	MARIE ANELAS	Customer Svc Representative	9452367	Employee

Topic: e-mail from member-update

Good afternoon I was seen by my Nuerologist Dr Paul Buechel of KCA Nuerology 4323 Carothers Pkwy, Franklin, TN 37067 (615) 550-1800

Dr Buechel seems to have determined what is causing my Back pain and feet numbing and pain. The new MRI shows Bone Spurs that are inoperatable. When the spurs press on a nerve, I am in pain or develop numbness or pain in my feet. I saw the letter addressed to me online. Dr Nyquist and Yanoyamo will update information but they probably will not do any kind of Disability determination. I will contact their offices to request information updates. I was also seen by Dr. James Renfro concerning some right shoulder complications. I will be participating in physical therapy for the next three weeks and sucess or failure will determine if additional surgery is required. I am available at anytime for a follow up call.

Claim Status	11/24/2014 10:58:32AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Provider
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Topic: No need for call to provider for f/u

No need for f/u call to provider Dr. Steven Nyquist submitted return fax to DBM on 11/21/2014. DBM will send out 30 letter to EE.

Claim Status	11/21/2014 2:39:03PM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Provider
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Topic: Call from provider office

DBM received vm from Amanda at Dr. Tad Yoneyama advising that EE has not been seen during the time frame requesting medicals.

Claim Status	11/06/2014 1:20:29PM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: LTD Claimant Interview

DBM contacted EE to get a better understanding of EE's oow condition. DBM inquired if EE was treating with chiro that he mention in email sent on 09/19/2014. EE informed that he is no longer treating with chiro. EE stated that the spinal deep compression was no good. EE advised that he will be treating with therapist (Jonathan Gish) first OV will be the second week of October. EE will also treat with psychiatrist ( Dr. Steven Nyquist) on 10/13/2014. DBM asked EE what is the condition preventing him from returning to work. EE informed the pain and burning in his feet. EE will be treating with PCP on 10/02/2014. EE informed that his cymbalta has been increase to 90 mg. EE states that he has difficulty with sleeping due to the pain that radiates from his feet to his back. EE informed that he can not sit for prolong period of time due to pain in feet and back. EE states that he can sit for 6-7 minutes before pain. EE advise that he does use the computer a total of 15 minutes a day. EE is capable of drive however only drives to take his son to school. EE states that he attends church but have difficulty with sitting. EE informed that EE has assistance with showering from his ex-wife. EE does nto cook. DBM inquired about classes EE informed that EE would take in the fall at MTSU. EE informed that he has not begin classes but may go in January 2015. EE has been denied. (See More)

Claim Status	10/06/2014 11:39:14AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Acknowledge call

DBM acknowledge call

Claim Status	10/06/2014 11:37:02AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Acknowledge call

DBM acknowledge call

E-mail from Member	10/03/2014 5:51:41AM	DOMINICA TAYLOR	OR CUSTOMER SRVC REPRESENTA	9452367	Employee
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Topic: update

Sorry I did not finish my last message. I am in pain doing my PT. I normally take Tramadol and 2 Arthritis Strength Tylenol, so I should complete class, ice my back and prop up my legs. The true benefits will be enjoying doing something, getting out of the house and not focusing on my pain for a bit.

E-mail from Member	09/30/2014 3:24:41PM	MARIE ANELAS	Customer Svc Representative	9452367	Employee
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Topic: e-mail from member-update

Good morning I would like to update my information concerning my phone conversation this morning. I have been following the Physical Therapy recommendations. I try to exercise, or stretch everyday but sometimes it is too painful. It was recommended to use the Elliptical machine versus a treadmill because the treadmill would be too stressful for my back. Using Tramadol and Arthritis Strength Tylenol I can normally use the machine for 20 minutes. I do my shoulder therapy exercises and I do my stretching at home. I believe the mental therapy will be helpful for my pain. When I first started the Cymbalta I was able to sleep 5-6 hours at night and did not experience burning in my feet all day. Now it appears I have to continue to increase the dosage for relief I believe the mental therapy will help me sleep and I am hopeful a better disposition, attitude and feeling of selfworth will help my daily life. I have become frustrated with medical and chiropractic relief claims but I will not give up hope of recovery.

# Central Note System - View All Report

[Click Here To Access The Excel Export View](#)

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	09/30/2014 11:25:52AM	SHAWNDR A LEE	LTD BENEFIT MANAGER	9452367	Employee

Topic: EE contacted for update on status

DBM contacted EE to get a better understanding of EE's oow condition. DBM inquired if EE was treating with chiro that he mention in email sent on 09/19/2014. EE informed that he is no longer treating with chiro. EE stated that the spinal deep compression was no good. EE advised that he will be treating with therapist (Jonathan Gish) first OV will be the second week of October. EE will also treat with psychiatrist ( Dr. Steven Nyquist) on 10/13/2014. DBM asked EE what is the condition preventing him from returning to work. EE informed the pain and burning in his feet.

EE will be treating with PCP on 10/02/2014. EE informed that his cymbalta has been increase to 90 mg. EE states that he has difficulty with sleeping due to the pain that radiates from his feet to his back. EE informed that he can not sit for prolong period of time due to pain in feet and back. EE states that he can sit for 6-7 minutes before pain. EE advise that he does use the computer a total of 15 minutes a day. EE is capable of drive however only drives to take his son to school. EE states that he attends church but have difficulty with sitting. EE informed that EE has assistance with showering from his ex-wife. EE does not cook.

DBM inquired about classes EE informed that EE would take in the fall at MTSU. EE informed that he has not begin classes but may go in January 2015. EE has been denied.

Claim Status	09/30/2014 10:45:11AM	SHAWNDR A LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Acknowledge call

DBM acknowledge call and will f/u with EE accordingly on disabling condition.

Claim Status	09/26/2014 1:02:13PM	SCHENIA HOLLIDAY	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: status

Tcf Mary Rowland, Lender ph 615-905-6200; calling to confirm length of payments. Per DBM, adv "Approved thru the end of November 2014, at which time we will f/u with provider office to obtain updated information to determine if condition continuously support claim"

E-mail from Member	09/19/2014 8:27:12AM	SUSAN STEWART	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: update from ee

Good afternoon I found the chiropractic treatments to be more harmful then good. My feet seemed to burn more, especially at night. I was not able to sleep following the treatments and it did not provide any back relief. I have discontinued treatment and will be making an appointment with a psychiatrist tomorrow.

Claim Status	09/15/2014 1:27:31PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: updated treatment plan

updated treatment plan

Claim Status	09/15/2014 1:18:43PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: return call to ee

STS left advised ee that Aetna Disability does not make recommendations or referrals for treatment

E-mail from Member	09/11/2014 12:07:45PM	ANASTASIA SNOOK	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: EE TX update

Good morning I have started Spinal Decompression treatment with Dr Derek Totty at Totty Chiropractic of Mt Juliet. 541 N Mt Juliet Rd, Mt Juliet TN 37122 615-758-7101. The session is supposed to run 20 treatments. I am open to any suggestions for pain relief.

E-mail from Member	08/16/2014 12:46:22PM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: update on claim

My next appointment is with Dr. Tad Yoneyama of Heritage Medical Clinic Jan 14th 2015. Current treatment is pain medication. I would be willing to go to any back specialist recommended by Aetna to help with the back pain.



# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	08/15/2014 1:01:06PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee

Topic: LTD Claimant Interview

Current Treatment: What is your current treatment plan? medication recreation center: physical therapy exercises daily basis. cant afford to continue to pay for pt physical therapy: last treatment may 2014 How do you think your recovery is progressing? not prgressing well. severe back pain What physicians are currently treating you? Dr. Yoneyama When was your last office visit with your physician(s)? July 2014 When is/are your next visit(s) scheduled? What are your current medications and dosages? (If any) tramadol - 50mg twice per day cymbalta -30mg once per day over the counter - arthritis tylenol How has your condition impacted your daily activities? (Housework, driving, child or elder care issues): not able to go many palces. drives son to school, takes a nap. if he has to shop his son or ex wife goes with him to lift bags. Who lives with you? moved in with ex wife to help with his expansives What are your thoughts on returning to work? not able to return to work Have you discussed this with your AP? have not had a discssion What contacts have you made with your employer since your disability.no Would you like any assistance in order to return to work? (Rehab program Note: Some contracts have mandatory rehab): OFF SETS: SSDI / WC / PENSION (Explain the ALLSUP process if applicable): had pycsch exam with ssa What is the status of your Social Security Disability claim? pending What are the dates of birth of your dependent children? REDACTED Are you eligible for a pension / retirement benefit from work? If so, are you currently receiving any benefits? no Are you receiving any benefits from Workers Comp? If so, ask for details including if a settlement is pending. no Assistive devices: not using any at this time.

Claim Status	08/04/2014 12:51:39PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: medication update

ee provided medication update

Claim Status	08/04/2014 12:50:31PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: appts.

dbm sending request to provider

E-mail from Member	08/02/2014 6:35:02PM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: update on claim

I tried to see my Pain Management doctor on Thursday July 31st and unfortunately I was 7 minutes late and she refused to see me. I have requested that my primary care doctor Tad Yoneyama, M.D. - Heritage Medical Associates provide my pain management treatment of Tramadol and Cymbalta versus Dr. Breanna Green. Dr Green has informed me previously that she cannot offer any other solution but pain medication and she charges twice as much for her consultations and I do not have the same personal relationship I have with my primary doctor. I feel he can offer better solutions.

E-mail from Member	07/15/2014 1:55:22PM	ANASTASIA SNOOK	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: EE medication update

I had an appointment with Dr. Tad Yoneyama at Heritage Medical Group, Franklin, TN

He suggested I try Cymbalta again. Eat before taking the medicine and try to work through initial side effects. Started last night and I will pickup script this morning.

Claim Status	07/09/2014 11:04:56AM	SHAWNDR A LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Obtain updated medicals from providers

DBM has request via fax updated medical information from Dr. Breena Green, Dr. Jason Knox, and Dr. Subir Prasad on 07/09/2014.

Claim Status	07/09/2014 11:03:37AM	SHAWNDR A LEE	LTD BENEFIT MANAGER	9452367	Provider
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Topic: Obtain updated medicals from providers

DBM have request updated medicals from Dr. Breena Green, Dr. Jason Knox, and Dr. Subir Prasad thru fax on 07/09/2014.

Claim Status	06/23/2014 10:52:50AM	JACOB PETERSON	SR CUSTOMER SERVICE REP	9452367	Employee
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Topic: TCF APO- Rachna for follow up on the claim for processing of pprwk

TCF APO- Rachna for follow up on the claim for processing of pprwk

APO informed that she had recvd the forms and both were far TOO small

Advised would have the pprwk sent again

n ofurther geustoions

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	06/20/2014 11:46:13AM	MARTHA WILEY	Customer Svc Representative	9452367	Provider

Topic: APS/CLW refaxed to APO  
TCF APO Nancy @ Dr. SUBIR PRASAD

APO called to req the APS/CLW to be refaxed to APO fax#: 615-916-3953 since the faxes rec'd were to small to read/complete.  
CSR refaxed APS/CLW to APO today to fax#: 615-916-3953 To Dr Subir Prasad.  
APO thanked CSR for assistance

Thank you  
Martha Wiley (CSR)

Claim Status	06/17/2014 10:20:08AM	BARTHOLOMAEA GASPARD	INTAKE REPRESENTATIVE	9452367	Employee
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Topic: DR OFFICE FLUP ON FAX REQUEST  
CHARLES REPORTED THAT DR KNOX DIDN'T PUT EE OOW PLS FAX REQUEST TO TREATING DR TO FILL OUT REQUEST

Claim Status	06/16/2014 2:38:47PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: req for medical records  
faxing request for current office visit notes

Claim Status	06/02/2014 3:03:57PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: vob letter  
mailing ee a vob letter

Claim Status	06/02/2014 3:02:57PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: STATUS UPDATE  
sts mailing ee provider form for him to list all new treating providers

Claim Status	06/02/2014 3:01:04PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: vob letter  
mailing ee a vob letter

Claim Status	06/02/2014 2:04:13PM	AKINKAWON TURNER	STD / LOA Benefit Manager	9452367	Employee
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Topic: reviewed  
dbm will contact ee regarding questions for claim

Claim Status	06/02/2014 11:42:01AM	TEMEKA JOHNSON	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: requesting dbm  
tCF ee wanting to speak with dbm.. he has been contacting her for awhile and havent gotten a response. DBM is unavailable so i was directed to reach out to WAnda, which was on the phone. I verified number and told him the dbm will contact him shortly.

E-mail from Member	05/30/2014 8:34:33PM	GLADYS WALTERS	Senior Customer Service Rep	9452367	Employee
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Topic: Member needs income verification letter  
Good morning I sent two requests and have not received a response from either. I would like to email updates directly to my case manager. I do need an income letter.

E-mail from Member	05/28/2014 12:14:46PM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: update on claim  
I would like the email address and contact phone number for my case manager please. I went to my Primary Care physician Dr. Tad Yoneyama at Heritage Medical Clinc. He believes I have a pinched nerve which is causing the painful burning of my feet. He was disappointed in the aloof attitude of Dr. Breanna Green not setting an urgency for the EMG. He is afraid the damage will continue and possible lead to numbness and muscle loss. I have scheduled an appointment with his referral Dr Subir Prasab of Heritage Medical Associates Thursday May 29th at 2:40PM



# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

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## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
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E-mail from Member

05/23/2014 12:35:30PM

THEODORA WILLIAMS

CSR

9452367

Employee

Topic: income letter

Email from member

I am trying to move and they would like a letter stating I will receive benefits beyond 2 yrs if I do not recover. Is this possible?

theo doar williams csr

Claim Status	05/07/2014 3:22:25PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: LTD BENEFIT APPROVAL

dbm advised ee of ltd benefit approval, shared monthly benefit amount and answered all questions

Claim Status	05/07/2014 2:38:55PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: CONFIRMATION OF SX DATE

HELEN FROM DR. RNEFRON'S OFFICE CALLED AND CONFIRMED EE'S LEFT KNEE SX WAS 4/18/2014

Claim Status	05/07/2014 12:44:15PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: req for medical records

faxing request from sx notes to dr renfro

Claim Status	05/07/2014 12:37:45PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: return call to ee

dbm advised ee claim is being reviewed, needed to confirm knee sx date

ee advised knee sx was performed 4/18/2014 and had f/u visit 4/26/2014

Claim Status	05/06/2014 5:26:09PM	KORIE LACHANCE	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: ppwrk needed

TCF EE who was calling to advise he was told he would get a call back today and did not receive on, CSR advised AR is set, EE will receive call back tomorrow. EE understood. CSR advised no determination yet.

Claim Status	05/06/2014 5:19:20PM	SANDRA ATWOOD	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: ee call re status of claim

ee call re status of claim, call dropped while ee on phone, plz cll ee back

Claim Status	05/05/2014 3:48:00PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: return call to ee

DBM ADVISED EE CLAIM WILL BE REVIEWED TOMORROW

E-mail from Member	05/05/2014 1:37:33PM	ANASTASIA SNOOK	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: EE req status

Will there be a decision tomorrow as promised?

Claim Status	04/28/2014 3:42:11PM	AKINKAWON TURNER	STD / LOA Benefit Manager	9452367	Employee
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Topic: rtc to ee

lvmm to advise claim under review ltd dbm will respond once an update is available

E-mail from Member	04/28/2014 1:25:03PM	ANASTASIA SNOOK	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: EE req status

I see my claims representative has changed, is there any update on my claim?

Claim Status	04/03/2014 9:44:01AM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Provider
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Topic: f/u with Dr. Green/PM&R

Sent a request to Dr. Green for APS and evaluation dated 03/25/2014

Claim Status	03/27/2014 4:13:02PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: status

outreach to ee to advise claim approved through eob and peer review requested

ee is willing to assist if there are any issues with reaching dr

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

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## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	03/20/2014 1:50:09PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee

Topic: rtc to dbm

helen rtc to dbm to advise ee has sx scheduled for 4/18/2014 for knee  
ee 6weeks out from shoulder sx however still doing pt 3x's a week for strength  
no f/u visit due to ee coming in for sx 4/18/2014

Claim Status	03/20/2014 1:47:08PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: pt notes

dbm spoke with phone rep requested pt notes to be sent for shoulder most recent  
rep indicated would send for review

Claim Status	03/19/2014 9:51:44AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: medical information

outreach to ee regarding pt notes, and notes regarding ee's back issues with dr cote  
ee indicated is going to pt today will have pw faxed for review, and will go directly to dr cote's office for pw to be sent regarding ee's back

Claim Status	03/18/2014 3:41:30PM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Employee
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Topic: knee surgery

Claimant informed me that she will have knee surgery April 18, 2014 by Dr. Renfro. Still pending records from Dr. Cote/back surgeon. Will be evaluated by PM&R 04/02/2014.

Claim Status	03/18/2014 3:08:41PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: JAMES RENFRO Orthopedic Surgery 12/13/2013 615-834-4482

outreach to dr renfro to confirm sx date  
lvmm for helen bottleworth to rtc with ee's nov date and if ee scheduled for knee sx

Payment Inquiry	03/13/2014 9:00:42AM	NADINE STOLARSKI	SR CUSTOMER SERVICE REP	8893435	Employee
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Topic: ee called about his pay

ee was advised we atp. claim approved to 3/11/14. meds rec to review. ee to fu with his er

Claim Status	03/07/2014 9:27:31AM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Employee
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Topic: status

Claimant has advised me via e-mail that Dr. Cote does not do disability paperwork but he will have the medical records faxed to me. He is going to pain mgt today and I requested he sent the contact information for pain mgt physician. I will advise STD.

Claim Status	03/07/2014 2:05:41AM		Not On File	8893435	Employee
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Topic: STD - RTW Autocall Results

First Name:ARTHUR Last Name:DAVIS Claim ID:8893435 Appr Thru Date:03/11/2014 Call Date/Time:2014-03-06 13:09:39 Call Attempt:1 Call Status:Inbound:  
Non-Responsive - Recipient hung up in header or failed to give a response to YN Authentication & system disconnected call Call Recipient Status: QUESTION: Are you RTW? QUESTION: May we transfer you?

Claim Status	03/07/2014 2:05:41AM		Not On File	8893435	Employee
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Topic: STD - RTW Autocall Results

First Name:ARTHUR Last Name:DAVIS Claim ID:8893435 Appr Thru Date:03/11/2014 Call Date/Time:2014-03-06 13:32:21 Call Attempt:1 Call Status:Inbound:  
Authenticated - Recipient Reached First Body Component Call Recipient Status: QUESTION: Are you RTW?NO QUESTION: May we transfer you?YES

Claim Status	03/07/2014 2:05:40AM		Not On File	8893435	Employee
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Topic: STD - RTW Autocall Results

First Name:ARTHUR Last Name:DAVIS Claim ID:8893435 Appr Thru Date:03/11/2014 Call Date/Time:2014-03-06 11:46:59 Call Attempt:1 Call  
Status:Authenticated - Recipient Reached First Body Component Call Recipient Status:OUTBOUND COMPLETE QUESTION: Are you RTW?NO QUESTION: May we transfer you?

Claim Status	03/06/2014 1:39:10PM	LINDSAY LAMB	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: rtw auto call

TCF EE he got the RTW auto call EE is not rtw on 3/12 he will need an extension, he stated that the AP should be sending updated medical info soon.

Claim Status	02/27/2014 3:05:52PM	PAUL FRUGE	Intake Representative	9452367	Employee
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Topic: TCF EE to see if tax form rec, CSR advised rec 2/26.'

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

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## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	02/21/2014 9:00:40AM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Employee

Topic: W4-S

I spoke to claimant and ask him to complete a W4-s. I provided him with the IRS website or the aetna disability website.

Was paperwork received	02/20/2014 1:46:35PM	JEREMY MOORE-WILLIAMS	customer service rep	9452367	Employee
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Topic: ee cking on p/w recieved

csr adv p/w recieved 02/20for reviewing by ltdm

Claim Status	02/18/2014 10:44:13AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: extended

outreach to ee to advise claim extended through nov 3/11/2014 need meds, pt notes. office visit notes to be sent for review  
lvmm

Claim Status	02/14/2014 2:18:45PM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Employee
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Topic: LTD Claimant Interview

Initial Documentation of telephonic interview: Claimant Name: Arthur Davis, Claim 9452367, Dell Inc. -----  
----- DO YOU HAVE AETNA HEALTH INSURANCE/ who is your carrier? Currently I have Aetna COBRA. HISTORY / ONSET OF  
CONDITION: If it began prior to the date of disability, or is long standing, what changed to cause them to stop working? My shoulder tendons fell off both my right and left shoulder. I was just mowing the lawn and lost full use of my arms. Unfortunately I was struck from behind and now have a Herniated Disc in my back which is causing severe pain along with my shoulder difficulties. What is your current medical treatment plan? I have therapy for my left shoulder two days a week. No therapy scheduled for right shoulder yet. Operation was on January 31st 2014. Is condition related to work in any way? Did you file a Workers Compensation claim? Name of company and claim adjuster? No, not work related. Do you have an attorney? Name, address, phone # David Clarke of Murfreesboro TN is representing me concerning the back injury. (615) 796-6299 111 North Maple Street, Murfreesboro, TN 37130 Did you have a non-work related injury or a MVA (Motor Vehicle Accident)? If so, how did the accident occur? When was the accident? Where? City and State? Any legal action pending due to original injury? Was a police report filed? If so, where was it filed? The back injury was a motor vehicle accident occurred September 27, 2014. Police report was filed with Murfreesboro TN police department. David Clarke is handling the case. Restrictions & Limitations? what did your physician advise you to avoid or that you should limit? I have a planned exercise program for my shoulders and back, I just do my therapy. My back problems have limited my activity as well. Height and weight: 6 feet 236lbs Name of all Medical Providers, provide phone and fax number.- How long have you been treating with them? October of 2014 to present. Dr. James Renfro of Premier Orthopaedics is treating me strictly for my shoulders. Dr. Christopher Kaufman was treating me for my back. November of 2014 to January 2015. 394 Harding Place. Nashville, TN 37211. Dr Nicholas Cote has taken over current back treatment. I attend therapy 3 times a week for my back. 1272Garrison Drive, Murfreesboro, TN 37129 Did you discuss your job duties with your provider? Yes Prescription medications/ what conditions are they prescribed for? I take Celebrex for my back and I have a number of painkillers for my shoulders and back when necessary. Describe a Typical Day/ ADLs: Back therapy at 9 or 9:30 until 10:30AM. Shoulder therapy at 11AM until 12PM. I come back home. Any help with household duties? Or shopping? Driving? Yard work? Child or elder care? My son helps with any large item shopping. I can do small item shopping. I don't drive a lot, it hurts my back and my shoulders. I hate to admit I have not cleaned my apartment since second surgery. My son lives with his mother, I am responsible for child support. Volunteer work? where, how often, how many hours? NA RTW (return to work) Status: Projected Date? What are your plans for work? (or retirement?) Dr. James Renfro is predicting a March return date for shoulders. No ETA concerning my back, very difficult typing this email, both shoulders and back pain. Duties and Requirements of your Occupation: At least 8-10 hours a day sitting at desk making calls and typing. Job Status with ER? Are they holding your job? When did you last speak with your supervisor? Dell have offered me a severance package, I have accepted. Will they allow part-time or light duty work or provide any accommodations? Would you like assistance with RTW? NA Earnings: Your employer indicates your earnings as: \$99,101.30/year. Do you agree? Yes Retiree

Claim Status	02/14/2014 10:08:42AM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Employee
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Topic: tPC

Left vmm for claimant to call me back.

Claim Status	02/14/2014 9:27:09AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: ee's pay

ee called to indicate that still short on his pay, ee feels that he is due 3000.00 additional dollars from er  
dbm advised that will see if payroll rep can contact ee to reconcile payments

Claim Status	02/14/2014 9:17:31AM	DEBBIE TAYLOR	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: Status of pmnts

tpc from ee for status of pmnts, CSR advised ER is ATP, EE wants to recd pmnt thru disability, call transd to DBM

Claim Status	02/13/2014 10:08:35AM	DONNA CHAPMAN	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: was pw received

tcf ee  
confirmed pw was received  
advised ee payments are handle through er  
confirmed claim approval dates

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

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## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	02/11/2014 2:04:04AM		Not On File	8893435	Employee

Topic: STD - RTW Autocall Results

First Name:ARTHUR Last Name:DAVIS Claim ID:8893435 Appr Thru Date:02/13/2014 Call Date/Time:2014-02-10 11:18:04 Call Attempt:1 Call Status:Answering Machine - Answering Machine Message Left Call Recipient Status:OUTBOUND IN-PROGRESS QUESTION: Are you RTW? QUESTION: May we transfer you?

Claim Status	02/11/2014 2:04:04AM		Not On File	8893435	Employee
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Topic: STD - RTW Autocall Results

First Name:ARTHUR Last Name:DAVIS Claim ID:8893435 Appr Thru Date:02/13/2014 Call Date/Time:2014-02-10 11:26:15 Call Attempt:1 Call Status:Inbound: Authenticated - Recipient Reached First Body Component Call Recipient Status: QUESTION: Are you RTW?NO QUESTION: May we transfer you?YES

Claim Status	02/07/2014 9:50:16AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: status

f/u with ee regarding approved extension, also need for meds from post-op visit for review

ee right hand dominate sx performed on 1/31/14

ee with therapy still on left shoulder attending today

and also therapy for back herniated disc

ee very miserable unable to sleep in his bed sleeps in a recliner chair was sleeping on a bean bag takes oxycodone for pain and to sleep at night

ee referred to eap for concerns with constant pain and also feeling miserable

Claim Status	02/04/2014 4:32:51PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: rtc to dbm

pat indicated that ee has f/u appt on 2/11/2014

fd rtw 6 months light duty rtw 1 month based on sx

dbm advised ee pdl is sedentary and will send jd to dr for review

Claim Status	02/04/2014 4:23:03PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: JAMES RENFRO Orthopedic Surgery 12/13/2013 615-834-4482

outreach to dr renfro to confirm f/u visit date, prtw date

lvmm for a rtc from helen

to rtc with f/u visit date and also rtw date

Claim Status	01/30/2014 2:54:38PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: update

outreach to ee to advise claim updated, also will confirm sx and update claim

ee understood

Returning Call	01/24/2014 1:12:56PM	SHAWNDR LEE	LTD BENEFIT MANAGER	8893435	Employee
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Topic: DBM rtc to EE

DBM rtc to EE regarding claim status. EE informed that EE would be schedule for sx on 01/31/2014. DBM inquired when was the last OVN with the provider. EE informed that he was last seen on 01/09/2014. DBM informed that she will request OVN from 01/09/2014 to be submitted to Aetna for review. EE then inquired when will his ER know that he should be paid thru 01/12/2014. DBM informed that Er was notified of extension on 01/09/2014. DBM advised EE to f/u with ER regarding payment.

Claim Status	01/24/2014 9:24:33AM	DOUGLAS HEYER	SR CUSTOMER SERVICE REP	8893435	Employee
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Topic: update

ee calling has not RTW is still out and will have SX on 1/31/14 no plans to RTW between now and then advised I would let the DBM know ee states medical we havealready states he would not RTW until 1/31/14 but now not even rtw then will have SX that day

E-mail from Member	01/19/2014 9:27:41PM	THEODORA WILLIAMS	CSR	8893435	Employee
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Topic: ee will need additional time oow

Email from member

Good afternoon I have scheduled surgery for my right shoulder for January 31st. Unfortunately my right shoulder has deteriorated quickly, the tear has gotten worst and I will not be returning to work until second shoulder has recovered.

theodora williams csr

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	01/17/2014 10:12:20AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee

Topic: reviewed  
reviewed

Claim Status	01/17/2014 10:10:46AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: rtc to ee regarding pay  
lvmm for a rtc with contact performing surgery, also to advise looking into pay issue

Claim Status	01/17/2014 9:31:23AM	MOHINEE VELIAN	USTOMER SERVICE REPRESENTATIVE	8893435	Employee
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Topic: I INFORM EE CLAIM IS APPROVED FROM 10/09-01/12 AND HIS ER IS PAYING, HE IS REQUESTING A CALL BACK  
I INFORM EE CLAIM IS APPROVED FROM 10/09-01/12 AND HIS ER IS PAYING , HE IS REQUESTING A CALL BACK

E-mail from Member	01/10/2014 8:01:18AM	THEODORA WILLIAMS	CSR	8893435	Employee
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Topic: sx date  
Email from member

I was seen by my surgeon this morning and have scheduled surgery for my right shoulder to repair the Torn Rotator Cuff in that shoulder. Surgery is scheduled for January 31st at 1PM. I was advised I should wait for second surgery to give my left arm more time to heal but I feel pressured to proceed.

Claim Status	01/03/2014 12:14:19PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: rtc to ee  
outreach to ee to advise requested pt notes, rom values, treatment plan, rtw date  
dr only sent in office visit note from 12/13

no meds to support an extension of std benefits

ee says fixing left shoulder, and right shoulder is getting worse  
ee doing pt two times a week ee can't lift and right arm is worse

Claim Status	01/03/2014 10:03:29AM	JACOB PETERSON	SR CUSTOMER SERVICE REP	8893435	Employee
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Topic: TCF EE for follow up on the claim for processing of benefit  
TCF EE for follow up on the claim for processing of benefit  
ADvised on the claim for processing of pprwk from 12/18/13  
ADvised still in review with the claim and not sure why not processed  
Reached out to DBM for update in the claim  
DBM unavial  
EE request c.b

Claim Status	12/13/2013 1:07:57PM	DOMINICA TAYLOR	OR CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: claim  
tcf ee re claim dell will be doing layoffs. adv as long as ee is still disabled ee can be out on std until 040614.

Claim Status	12/05/2013 2:27:09PM	DOMINICA TAYLOR	OR CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: fax number  
tcf ee re fax number  
adv to put claim number at top of form  
adv fax number 866-667-1987

Claim Status	12/05/2013 11:08:34AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: reviewed  
update

Claim Status	12/05/2013 11:02:21AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: rtc to dbm  
sue indicated ee's nov is on 12/13/2013 for review

Returning Call	12/05/2013 11:01:53AM	ANNIE SANTOS	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: update  
TCF EE says his NOV is on 12/13/13 w/Dr.Renfro and will be faxing in ROI form.

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	12/05/2013 10:37:08AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee

Topic: f/u with ee  
outreach to ee to advise trying to confirm nov date, also if ee can provide release of information request with provider  
so we can update claim

lvmm for a rtc with nov date

Claim Status	12/05/2013 10:22:28AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: JAMES RENFRO Orthopedic Surgery 615-834-4482  
outreach to dr renfro  
spoke with sue in scheduling would not release the nov date due to hippa law

Claim Status	12/02/2013 1:09:41PM	RHONDA SICIARIDIS	STD Claim Analyst	8893435	Employee
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Topic: pending claim recert  
RECEIVED CALL FROM EE. VERIFIED CLINICALS RECEIVED 11/21/13. EXPLAINED REVIEW/RECERT PROCESS. ADVISED DBM WILL CONTACT ONCE REVIEW IS COMPLETE.

Claim Status	11/26/2013 1:37:54PM	LORI BRADSHAW	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: claim status  
tcf ee wanted to know claim status  
csr stated that medialinfo is in review that we rec'vd on 11/21  
ee understood

Claim Status	11/20/2013 10:00:50AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: reviewed  
will contact ee once update is available

Claim Status	11/20/2013 9:16:54AM	KARINA TABORDA	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: tcf ee  
ee wanted to know why claim still states he will rtw on 11/25. advs ee that claim still in review. ee asked for dbm to contact him when review complete

Payment Inquiry	11/01/2013 9:19:01AM	MARY BELL-THOMPSON	Sr Customer Service Rep	8893435	Employee
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Topic: Payment  
tcf ee called to confirm payment dates, ee advised claim is ATP W/ CAL. EE was referred back to his employers to confirm payment dates.

Payment Inquiry	10/24/2013 4:51:50PM	ERIC PECKHAM	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: EE cld in  
TCF EE inq abt pymnt info if mailed or dir dep. Adv pymts handled ER adv to verify w/ER to confirm. Benefit Schedule:WEEKLY. EE inq if get right shoulder done  
would claim be approved. Adv claim would pend based ff When Sx performed for right side.

Claim Status	10/17/2013 5:44:31PM	KELINDA WARLING	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: claim status  
tcf ee stated he made call this morning and also sent email adv claim was approved 10-9-13 thru 11-24-13 adv fmla was approved also adv ee close to rtw will f/u  
and if ee needs to ext will req ovn adv atp/calcs adv 7 day e/p

Claim Status	10/17/2013 10:55:10AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: reviewed  
reviewed

Claim Status	10/16/2013 11:23:12AM	JOHN WORLEY	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: tcf ee  
tcf ee - received aps and additional notes , adv is under rev

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	10/15/2013 2:36:12PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee

Topic: rtc regarding dates  
ee indicated fda 10/9 as ee ws unable to work was in pain on narcotics had sx on 10/11 two rotator cuff tears which required sx, dbm advised ee need meds from dr to support days prior as only sx information and mri however nothing indicating ee unable to work prior

ee understood

Returning Call	10/15/2013 2:19:32PM	BRENDA WATERS	csr	8893435	Employee
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Topic: ee rtc  
ee rtc  
ee was giving dates that he was out in sept. asking dont these days count..  
csr explained that cm needed to know the fda for the claim right now.. ee stated 10 09  
cm will call ee back to clear this up

Claim Status	10/15/2013 1:57:39PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: clarify dates oow  
lvmm to advise fda/dos would be 10/11 days oow prior are non disability days  
dbm will proceed with update and advise ee

Claim Status	10/15/2013 1:23:58PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: fda 10/11 sx date vacation days prior  
review confirm and update

Claim Status	10/14/2013 12:58:05PM	LESLEY DUTIL	Customer Srvc Representative	8893435	Employee
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Topic: rtcf ee  
rtcf ee, I asked ee to confirm following:  
LDW 10/8  
FDA 10/9  
SX date 10/11  
ee took vacation days for 10/9 & 10/10  
NOV 10/18  
PRTW 4 weeks or longer  
SX TYPE rotator cuff  
HOSPITALIZATION DATES admitted 10/11 discharged 10/11  
ee will lfup with apo for aps to be returned

Claim Management Process	10/11/2013 4:07:58PM	SHATOYA ROBEY	Disability Benefits Manager	8893435	Employee
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Topic: INITIAL EE CONTACT  
IA CALLED EE **REDACTED** AND LVM FOR EE TO RTC TO AETNA  
SR 10/11/2013 407PM  
NEED TO CONFIRM:  
FDA  
LDW  
NOV  
PRTW  
DX  
SX DATE(IF APPLICABLE)  
SX TYPE(IF APPLICABLE)  
HOSPITALIZATION DATES(IF APPLICABLE)  
NEED TO ADVISE EE WILL BE PLACED ON PENDING LEAVE AND WILL NOT BE PAID UNTIL STD HAS BEEN APPROVED. ALSO ADVISE EE OF 7 DAY WP AND ADVISED EE CAN USE PBA/VAC TO COVER TIME OOW UNTIL STD IS APPROVED, AND IF STD IS APPROVED EE WILL BE REIMBURSED EE'S PBA/VACATION EXCEPT TIME USED FOR WP

Forms	10/10/2013 4:41:46PM	MAHADI THASSIM	CUSTOMER SRVC REPRESENTATIVE	8893560	Employee
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Topic: ee in received std/fmla package with wrong claim #  
adv portal to download correct forms



# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	10/10/2013 11:22:10AM	CHERYL RUTH	CUSTOMER SRVC REPRESENTATIVE	Employee	Employee

Topic: ee transferred to make a STD claim

EE transferred to make a STD claim, he thought that was what he made, but he told rep to make it a intermittent claim, he needs continuous claim .

Supervisor: Susan Park

Phone: 512-513-2701

Display: 518-451-3000 x 78738

\*Actual FDA is 10/08/2013.

Actual LDW 10/07/2013

Already selected for an FMLA claim so I selected 10/2/2013 and using 10/1/2013 as LDW \*\*EE on more than 2 medications a day

Claim Status	10/10/2013 10:55:36AM	TERESA CRESPO	STD / LOA BENEFIT MANAGER	8864540	Other
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Topic: ee requesting add std to loa

acknwldg, open a std claim

Claim Status	10/10/2013 10:53:51AM	ANASTASIA SNOOK	CUSTOMER SRVC REPRESENTATIVE	8864540	Employee
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Topic: EE SX date

TCF EE to advise his SX is 10/11. EE advised he has not recv'd anything in the mail, CSR advised need HCPC to approve the claim. EE advised need STD claim opened, thought did yesterday. CSR advised not STD open, only FMLA intermittent. CSR transferred EE to Intake to open STD claim.

Claim Status	10/08/2013 4:17:12PM	SHARLYNN DARRIS	CUSTOMER SRVC REPRESENTATIVE	8864540	Employee
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Topic: ee requesting add std to loa

ee is having surgery for same condition as existing intermitten loa claim.

please change status from intermitten to continuoius and add std

FDA: 10/9/

LDW: 10/8

\*\*GAP: intermitten loa claim 10/9- 11/11

RTW: 4 weeks 11/11/13, then start therapy

Hospital: Premier Orthopaedics @ 615-332-3600

Dr: james renfro @ 394 harding place nashville tenn 37211

Claim Status	10/08/2013 4:07:39PM	BAMBI JEREMICZ	CUSTOMER SRVC REPRESENTATIVE	8864540	Employee
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Topic: New Claim

New Claim Transferred ee to Intake.

Claim Status	10/07/2013 5:12:20PM	BAMBI JEREMICZ	CUSTOMER SRVC REPRESENTATIVE	8864540	Employee
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Topic: EE calling in surgery information

EE called to advise he will be having out patient surgery on 10/11/2013 at Premier Orthopedics. Advise ee to call and confirm on 10/10/2013 that he is still having his surgery so we can follow up for any additional information that may be needed. EE also called in days out from 10/8/2013 ,10/09/2013,10/10/2013 and 10/11/2013 all full days. Transaction Number 8877357

Claim Status	10/07/2013 12:05:17PM	TERESA CRESPO	STD / LOA BENEFIT MANAGER	8864540	Other
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Topic: EE REPORTED 09/09, 09/19, 09/27 AND 10/07 FROM 07AM-09AM AND 10/07 FROM 02PM-04PM

acknwldg

Claim Status	10/04/2013 5:31:11PM	MOHINEE VELIAN	USTOMER SERVICE REPRESENTATIVE	8864540	Employee
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Topic: EE REPORTED 09/09 , 09/19, 09/27 AND 10/07 FROM 07AM-09AM AND 10/07 FROM 02PM-04PM

EE REPORTED 09/09. 09/19 AND 09/27 AND 10/07 FROM 07AM-09AM AND 10/07 FROM 2PM-04PM





PO Box 14560  
Lexington, KY 40512-4560  
TERESA CRESPO  
STD / LOA BENEFIT MANAGER  
Phone: 800-354-1779  
Fax: 1-866-667-1987

10/07/2013

ARTHUR DAVIS

REDACTED

MURFREESBORO TN - 37128

**Employer: Dell Inc**  
**RE: Preliminary Designation of Request for Family Medical Leave**  
**Claim Number: 8864540**

Dear MR. ARTHUR DAVIS:

Aetna Life Insurance Company ("Aetna") administers leaves for **Dell Inc** under the Family and Medical Leave Act (FMLA), applicable state law and leave policies of **Dell Inc**.

**Request for Leave**

On **10/4/2013**, you notified us of your need to take the following Intermittent leave(s):

**Federal Family and Medical Leave Act (FMLA)**

**Date(s) of Absence**

Beginning on **9/9/2013**

The leave was requested due to: Employee's own health condition

Your leave(s), if approved, is scheduled to commence on 9/9/2013.

This letter is to inform you that you are eligible to receive FMLA leave scheduled to begin on 9/9/2013. Please note, your FMLA leave request has not yet been approved (see requirements below). Please submit the necessary information identified in Section C below by no later than close of business on 10/25/2013. If this information is not provided in a timely manner, your leave may be denied.

**Federal Family and Medical Leave Act (FMLA)**

Under the FMLA, except as explained below, eligible employees have a right to leave for the reasons described here. Please note, an employee shall give at least 30 days' notice before the date on which the leave will begin if possible; if the leave is unforeseeable, notice should be provided as soon as is reasonable and practicable.

- A. Up to 12 weeks of unpaid leave in a 12-month period may be approved for the following reasons:
  - 1. Because the employee is unable to perform the functions of his or her job due to his or her own serious health condition;
  - 2. For the care of a spouse, son, daughter, or parent with a serious health condition ('spouse' covers marriages that are recognized in the state where the employee lives);
  - 3. For the birth and care of a newborn child;
  - 4. For placement of a son or daughter with the employee for adoption or foster care; or
  - 5. Due to a qualifying exigency arising out of the employee's spouse, son, daughter, or parent being on active duty, receiving a call to order to active duty in support of a contingency operation, or being deployed to a foreign country
- B. Up to 26 weeks of unpaid leave in a 12-month period may be approved for the following reason:
  - 1. To care for a covered servicemember with a serious injury or illness, if the employee is the spouse, son,

daughter, parent, or next of kin of the servicemember.

**A. Serious Health condition:**

A serious health condition under FMLA means an illness, injury, impairment or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. Continuing treatment (explained more fully on "Appendix A," attached at the end of this Notice), includes any one or more of the following: (1) incapacity and treatment; (2) employee's pregnancy or pre-natal care; (3) a chronic condition; (4) permanent or long-term conditions; or (5) conditions requiring multiple treatments.

**B. Preliminary Designation**

This notice serves as a Preliminary Designation for the leave(s) you requested, subject to our receiving a completed Health Care Provider Certification form or other required information (i.e. second or third medical opinion, employment records, etc.) needed to process your leave request within the required timeframe. Absences are not approved until a final determination is made by Aetna.

**C. Documentation needed to certify the leave(s):** Enclosed is an Authorization for the Release of Medical Information. This form is requested to assist Aetna in gathering information associated with your FMLA or state leave. Please complete the form and return it to Aetna at the above referenced address as quickly as possible. You may also fax it to Aetna at 1-866-667-1987.

- Enclosed is the Health Care Provider Certification (HCPC) form. It is your responsibility to obtain a completed HCPC form from the health care provider who is treating you or your qualified family member. Please have the health care provider complete the enclosed HCPC form and return it to the above referenced address by close of business on 10/25/2013. Alternatively, your health care provider can fax this form to 1-866-667-1987.
- If the requested absence is due to bonding, adoption or foster care, your employer may require proof such as a written statement / affidavit, birth certificate, or court documentation. The Authorization for the Release of Medical Information and Health Care Provider Certification are not required.
- Sufficient documentation to establish the required relationship between you and your family member.

**D. Important Information About Your Rights and Responsibilities Under FMLA:** Your health benefits will be maintained during any period of approved FMLA leave under the same conditions as if you continued to work, and are subject to your continued employee contributions. You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave.

You may be required to furnish re-certification relating to a serious health condition. As noted above, if your leave is on an intermittent basis, re-certification may be required as frequently as every thirty (30) days

For additional details, please refer to the attached "Statement of Employee's Rights and Responsibilities under Family Medical Leave Act".

Once we obtain the required information from you as specified above, we will inform you within five (5) business days whether or not your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. Failure to furnish the required documentation by close of business on 10/25/2013 may result in the denial of your leave request.

Please review the additional enclosed information regarding Dell's Family and Medical Leave Policy. Please contact me at 800-354-1779, with any questions regarding your leave or this letter.

Sincerely,

TERESA CRESPO  
STD / LOA BENEFIT MANAGER

Enclosures:

Return Envelope

Important Info About Dells Family and Medical Leave Policy

Fitness For Duty - Dell

Authorization for Release of Medical Information for Leave of Absence

Employee Rights and Responsibilities under FMLA

FML Certification - Employee Serious Health Condition

Appendix A: Explanation of Continuing Treatment  
WorkAbility Portal Flyer

**Important Information about Dell's Family and Medical Leave Policy**

- **Fitness to Return to Work** – If you are on a medical leave, you will be required to present your employer with a fitness-for-duty certification in order to return to work. Failure to provide this certification will delay your return to work and may impact your pay. Limited capabilities: If accommodation for work restrictions or reduced schedule is required, you must submit a fitness-for-duty certification at least 2 business days prior to your return date.
- **PBA and Vacation** – You must use available PBA and/or Vacation during any otherwise unpaid FMLA leave, with the option of reserving five days. Please contact your manager to make arrangements for the use of your PBA and/or Vacation. Any paid time off used will be counted against your available leave under the FMLA. After you have exhausted your available PBA and/or Vacation, the remainder of your leave will be without pay. If you are receiving workers' compensation or disability benefits, then you may not use your PBA or Vacation.
- **Intermittent Absence Reporting** - If an intermittent leave is certified by the health care provider, you must notify Aetna and your manager each time you need to take intermittent leave for the certified reason. Intermittent absences must be reported to Aetna at (800) 354-1779 within 2 business days after you return to work. Failure to report an intermittent absence within 2 business days of returning to work may result in disciplinary action.
- **Continuation of Benefits** - During your leave, the benefits for which you are currently enrolled will be continued and the Dell-sponsored portion will continue to be paid by Dell. You will still be responsible for paying any monthly premiums. During a paid leave, your premiums will continue to be paid through payroll deductions. The Dell Benefits Center will provide you with information regarding arrangements for payment of your share of the premiums during any unpaid leave. You have a 30-day grace period in which to make such premium payments. In the event that you do not pay your share of the insurance premiums on a timely basis, your insurance coverage for yourself and/or your dependents may be terminated.
- **Dependent Care (Day Care) Flexible Spending Account Program Exception:** Your contributions to your Dependent Care (Day Care) Flexible Spending Account will automatically be suspended when you begin FMLA. To reinstate your Dependent Care (Day Care) Flexible Spending Account election, you must contact the Dell Benefits Center within 31 days of the date you return to work.

**Please contact the Dell Benefits Center at 1-888-335-5663, Option 1 for more information regarding benefit continuation during your leave.**

- **Other Types of Leave** – For information regarding other types of leave possibly available through your employer, please contact your manager or HR Generalist.





## Fitness-For-Duty Certification

Employee Name: \_\_\_\_\_ Badge No: \_\_\_\_\_ Date Leave Began: \_\_\_\_\_

Employee Social Security Number: \_\_\_\_\_ Home Phone: \_\_\_\_\_

### INSTRUCTIONS FOR EMPLOYEE

This form is important. Please read it carefully. This form will be used to evaluate your ability to return to your job, to determine whether you are a candidate for participation in Dell's Stay @ Work /Return to Work program, and to evaluate any accommodation you may require to return to your job. ***Failure to properly complete this form and return it by the deadline may result in disciplinary action, up to and including termination of your employment.***

**If you have been away from work, the completed form must be returned at least two business days before your return to work.** If you are not able to return to work, you must return this form at least two business days before you use up all of your leave time. If you are or will be released to **restricted duty** and you have not used up all of your available leave time under the FMLA, you may continue your leave until you are able to return to work without restrictions or until you exhaust your available leave time, or you may request to return to restricted duty. If you do not know how much leave time you have remaining, call 8-1111 or 1-888-335-5663 and select option 5.

**If you have not been absent from work and have work restrictions,** please complete the following medical release: I hereby authorize my treating health care provider(s) to release to Dell any information regarding my ability to work.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### **HEALTH CARE PROVIDER TO COMPLETE THE FOLLOWING:**

I certify the following return to work status for the above named employee:

☐ **No restrictions**—employee may return to work without restrictions Date of return \_\_\_\_\_

☐ **Restricted duty**—employee may return to work with restrictions Date of return \_\_\_\_\_

*If you check Restricted duty, please complete next page*

☐ **Employee is unable to return to work** Estimated date of return \_\_\_\_\_

Incapacity is/Restrictions are: ☐ **TEMPORARY** Estimated end date of restrictions \_\_\_\_\_

☐ **PERMANENT or INDEFINITE**

Name of health care provider (print): \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Fax completed form to: (866) 667-1987

or mail to: Actna, PO Box 14560, Lexington, KY 40512-4560

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### RESTRICTIONS

Employee Name: \_\_\_\_\_ Badge No: \_\_\_\_\_ Date: \_\_\_\_\_

#### **SCHEDULED RESTRICTIONS:**

Scheduled Absences for Treatment (please list schedule, duration and frequency): \_\_\_\_\_

Max. Hours/Day: \_\_\_\_\_ Max. Hours/Week: \_\_\_\_\_

Required Breaks Duration: \_\_\_\_\_ Frequency: \_\_\_\_\_

POSTURE/MOTION CAPABILITIES	HOURS (Circle Hours Patient Can Perform Each Posture/Motion)														RESTRICTIONS (Circle if No Restriction)
STANDING:	0	1	2	3	4	5	6	7	8	9	10	11	12	NONE	
SITTING:	0	1	2	3	4	5	6	7	8	9	10	11	12	NONE	
KNEELING/SQUATTING:	0	1	2	3	4	5	6	7	8	9	10	11	12	NONE	
PUSHING/PULLING:	0	1	2	3	4	5	6	7	8	9	10	11	12	NONE	
TWISTING/BENDING:	0	1	2	3	4	5	6	7	8	9	10	11	12	NONE	
WALKING:	0	1	2	3	4	5	6	7	8	9	10	11	12	NONE	
CLIMBING:	0	1	2	3	4	5	6	7	8	9	10	11	12	NONE	
REACHING:	0	1	2	3	4	5	6	7	8	9	10	11	12	NONE	
KEYBOARDING:	0	1	2	3	4	5	6	7	8	9	10	11	12	NONE	
GRASPING/SQUEEZING:	0	1	2	3	4	5	6	7	8	9	10	11	12	NONE	
LIFTING/CARRYING:	0	1	2	3	4	5	6	7	8	9	10	11	12	NONE	

\*LIFT/CARRY # of lbs. ☐ 10lbs. maximum ☐ 20lbs. maximum ☐ 30lbs. maximum ☐ other \_\_\_\_\_

#### **MISCELLANEOUS RESTRICTIONS:**

Required orthopedic aids (e.g., splint, brace, etc.): \_\_\_\_\_

☐ No driving/operating heavy equipment

Explanation of above or any other restrictions: \_\_\_\_\_

Fax completed form to: (866) 667-1987

or mail to: Actna, PO Box 14560, Lexington, KY 40512-4560

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## Authorization for Release of Medical Information – Leave of Absence

Mail this completed form to:  
Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Fax: 1-866-667-1987

This form requests an Employee's express authorization ("Authorization") for Aetna Life Insurance Company ("Aetna") to ask another person or organization to disclose Employee's Protected Health Information ("PHI") to Aetna for the following limited purpose(s):

### Administration of leave of absence requests ("leave requests") under the Federal Family and Medical Leave Act (FMLA) and state family and medical leave laws.

We are asking you to allow Aetna to discuss PHI with your health care provider to clarify information on the Health Care Provider Certification Form (the "Medical Certification") submitted to Aetna in support of your leave of absence request. Clarification may entail questions about the health care provider's handwriting on the Medical Certification or questions to understand the meaning of a response on the Medical Certification. Additionally, we are asking you to allow your health care provider or Aetna to share PHI pertaining to your serious health condition, to a health care provider who Aetna may retain to perform a second or third opinion on your request for a leave of absence.

I understand the following:

- There may be a delay in the processing of my leave request if clarification of Medical Certification, or a second or third opinion are necessary.
- This Authorization lasts twelve (12) months after my leave request is processed, unless law requires a shorter period.
- I may revoke this Authorization at any time by notifying Aetna in writing, but if I do that, it won't have any effect on actions that Aetna takes before receiving my revocation notice.
- If I do not sign this Authorization, it will not affect how Health Care Providers treat me. However, Aetna may not be able to review my leave request to determine if I am eligible for benefits, and my leave request may be denied.
- I may receive a copy of this Authorization if I make my request in writing to the address listed above.
- Once my Information is given out as allowed in this Authorization, federal privacy laws may not protect it.
- The Information released under this Authorization may be submitted to Aetna electronically, by phone, fax or mail.
- I can see or copy this signed form if I ask Aetna for it in writing.
- A copy of this Authorization may be treated as a signed original.

### NOTICE TO RECIPIENT(S) OF INFORMATION:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. ***Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.***

Employee's Name	Date
Employee's or Legal Representative's Signature	Legal Representative's Name and Relationship
Employer's Name	

**If your leave is being requested to Care for a Family Member please have your family member or his / her legal representative complete the section below.**

Family Member's Name (Patient)	Date
Family Member's or Legal Representative's Signature	Legal Representative's Name and Relationship

WKAB  
GR-68474





**EMPLOYEE RIGHTS AND RESPONSIBILITIES  
UNDER THE FAMILY AND MEDICAL LEAVE ACT**

**Basic Leave Entitlement**

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

**Military Family Leave Entitlements**

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

**Benefits and Protections**

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

**Eligibility Requirements**

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

**Definition of Serious Health Condition**

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

**Use of Leave**

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

**Substitution of Paid Leave for Unpaid Leave**

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

**Employee Responsibilities**

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

**Employer Responsibilities**

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

**Unlawful Acts by Employers**

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

**Enforcement**

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

**FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.**



For additional information:  
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627  
**WWW.WAGEHOUR.DOL.GOV**



U.S. Department of Labor | Employment Standards Administration | Wage and Hour Division

WHD Publication 1420 Revised January 2009







**Family Medical Leave Act (FMLA) Certification for  
Employee's Serious Health Condition<sup>1</sup>**

Return completed form to: Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Fax: 1-866-667-1987

**SECTION I: For Completion by the EMPLOYEE:**

**INSTRUCTIONS to the EMPLOYEE:**

Please complete Section I before giving this form to your medical provider. The FMLA permits an employer<sup>2</sup> to require that you submit a timely, complete, and sufficient medical certification to support your request for FMLA leave due to your own serious health condition. If requested by your employer, completion of this certification is needed for you to get or keep the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a delay or denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Last Name DAVIS	First Name ARTHUR	Middle Initial
Employer Name Dell Inc	Job Title	

Job Description & Essential Job Functions (Please describe with details):

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How many hours are you scheduled to work each week? \_\_\_\_\_

Please circle your scheduled work days: SAT SUN MON TUE WED THUR FRI

If your schedule varies each week, please check here: ☐

On the days that you work, are you scheduled to work the same number of hours each day? ☐ No ☐ Yes

What time are you scheduled to begin and end your work day? \_\_\_\_\_

Are you paid overtime if you work more than 40 hours in a week? ☐ No ☐ Yes

**What is the reason for your FMLA request?**

☐ Employee's serious health condition (other than pregnancy):

☐ Pregnancy/Childbirth - Estimated Date of Delivery: \_\_\_\_\_

**Employee's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<sup>1</sup> This Certification may also be used for certification of state leaves and employer's company leaves.

<sup>2</sup> Reference to your employer extends to Aetna in its capacity as your employer's third party administrator.



**SECTION II: For Completion by the HEALTH CARE PROVIDER:**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient, referred to here as "the employee," has requested leave under the FMLA. Please answer all applicable sections fully and completely. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the employee. Be as specific as you can; terms such as "as medically necessary," "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. ***Please limit your responses to the condition for which the employee is seeking leave***, and be sure to sign the form on the last page.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Employee's Name: \_\_\_\_\_

Provider's name and business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

**PART A: MEDICAL FACTS**

1. Please provide the following information regarding the employee's medical condition.

Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

**Mark below as applicable:**

Was the employee admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☐ No ☐ Yes If yes, dates of admission and duration of stay:

\_\_\_\_\_

Date(s) you treated the employee for the condition requiring leave: \_\_\_\_\_

Most recent date of treatment by you or another provider: \_\_\_\_\_

Will the employee need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes

Will the employee need to be treated again in the future for this condition? Please provide dates of any such treatments that have been scheduled, or, if no future treatments have been scheduled, please indicate when and how often they will be needed.

\_\_\_\_\_

Has medication, other than over-the-counter medication, been prescribed? ☐ No ☐ Yes

Has the employee been referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ No ☐ Yes



2. Is the medical condition pregnancy? ☐ No ☐ Yes

If so, expected delivery date: \_\_\_\_\_

3. Use the information provided by the employer, if available, to answer these questions. If the employer has not provided a list of the employee's essential functions or a job description, please answer these questions based upon the employee's own description of his or her job functions.

Is the employee unable to perform any of his or her job functions due to the condition? ☐ No ☐ Yes

If so, identify the job functions the employee is unable to perform:

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4. If the treating provider is a chiropractor, does the treatment being provided to the employee consist of manual manipulation of the spine to correct a subluxation as demonstrated by an X-ray? ☐ No ☐ Yes
5. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

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## PART B: AMOUNT AND NATURE OF LEAVE NEEDED

6. When will the employee be incapacitated from work? (Please select and complete one of the options below.)

☐ From \_\_\_\_\_ through \_\_\_\_\_, with an expected return to work on \_\_\_\_\_.

(If the employee will also need to be absent from work intermittently due to his or her condition before or after this time period, please complete question 7. If the employee will need to work a consistently reduced number of hours due to his or her condition before or after this time period, please complete question 8.)

☐ Beginning on \_\_\_\_\_ and lasting for the following amount of time: \_\_\_\_\_.

(If the employee will also need to be absent from work intermittently due to his or her condition before or after this time period, please complete question 7. If the employee will need to work a consistently reduced number of hours due to his or her condition before or after this time period, please complete question 8.)

☐ The employee is or will be incapacitated intermittently, not for a specific timeframe. (Please complete question 7.)

☐ The employee can continue working, but will need to work a consistently reduced number of hours per day or per week. (Please complete question 8.)



7. If the employee will need to be absent intermittently, please provide the following information. The employee's work schedule may be available on page 1 for reference.

- How long will the employee be affected by this condition? \_\_\_\_\_
- Will the condition cause episodic or unpredictable flare-ups periodically preventing the employee from performing his or her job functions? ☐ No ☐ Yes

Is it medically necessary for the employee to be absent from work during these flare-ups?

☐ No ☐ Yes If yes, please explain:

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If you answered yes to both prior questions, please estimate the frequency of flare-ups and the duration of related incapacity that the employee may experience over the next 6 months, based on the employee's medical history and your knowledge of the medical condition (e.g., 1 episode every 3 months lasting 2 days):

FREQUENCY: \_\_\_\_\_ time(s) every: \_\_\_\_\_ ☐ week(s) \_\_\_\_\_ ☐ month(s)

(Example: 1 time(s) every: \_\_\_\_\_ ☐ week(s) 3 ☒ month(s) to indicate "once every 3 months")

DURATION: \_\_\_\_\_ ☐ hour(s) \_\_\_\_\_ ☐ day(s) per episode

(Example: \_\_\_\_\_ ☐ hour(s) 2 ☒ day(s) per episode to indicate "2 days per episode")

- Will intermittent absences be required due to follow-up or other medical appointments? ☐ No ☐ Yes

If yes, please estimate the frequency of these appointments and the duration of absence required for these appointments, including the time it may take for the employee to travel to the appointments (e.g., 1 time every 3 months lasting 2 hours):

FREQUENCY: \_\_\_\_\_ time(s) every: \_\_\_\_\_ ☐ week(s) \_\_\_\_\_ ☐ month(s)

(Example: 1 time(s) every: \_\_\_\_\_ ☐ week(s) 3 ☒ month(s) to indicate "once every 3 months")

DURATION: \_\_\_\_\_ ☐ hour(s) \_\_\_\_\_ ☐ day(s) per appointment

(Example: 2 ☒ hour(s) \_\_\_\_\_ ☐ day(s) per appointment to indicate "2 hours per appointment")

8. If the employee's condition will require him or her to work a reduced work schedule, please provide the following information. The employee's regular work schedule may be available on page 1 for reference.

Is it medically necessary for the employee to work a reduced number of hours? ☐ No ☐ Yes

If yes, please explain: \_\_\_\_\_

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- How long will the employee be affected by this condition? \_\_\_\_\_
- How many hours will the employee be able to work per day?  
Mon \_\_\_\_\_ Tue \_\_\_\_\_ Wed \_\_\_\_\_ Thurs \_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_ Sun \_\_\_\_\_  
Or: how many hours will the employee be able to work per week? \_\_\_\_\_



- What medical restrictions will the employee have, if any, while working these reduced hours?

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- When will the employee be able to resume his or her regular work schedule? \_\_\_\_\_

**ADDITIONAL INFORMATION:  
IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

**Signature of Health Care Provider**

**Date**





## **Appendix A: EXPLANATION OF CONTINUING TREATMENT**

### **Incapacity and Treatment**

Incapacity and treatment entails a period of more than three (3) full calendar days and subsequent treatment or incapacity that involves; (a) in person treatment with a health care provider two (2) or more times within a thirty (30) days of your first incapacity, or (b) in person treatment with your health care provider at least once within the first seven (7) days of incapacity, which results in regimen of continuing treatment under your health care provider's supervision.

### **Chronic Condition**

A chronic condition (a) requires periodic visits for treatment by a health care provider at least twice a year, (b) continues over an extended period of time (including recurring episodes of a condition); and which (c) may cause episodic incapacity rather than a continuing period of incapacity,

### **Permanent or Long Term Condition**

A permanent or long term condition entails a period of incapacity for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider (e.g. Alzheimer's terminal stages of an illness).

### **Conditions Requiring Multiple Treatments**

Any period of absence to receive multiple treatments (including period of recovery) by a health care provider or a provider of health care services.

**[NOTE: IN THE STATE OF CT. THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT]**







## WorkAbility® Absence Management System

A better way to keep track of your claim

The site is so easy to use. You can log in any time, day or night.

### [www.aetnadisability.com](http://www.aetnadisability.com)

You've created a claim with us because you need to be out of work. Now your focus is making sure the process goes smoothly so if your claim is approved, you get paid correctly and on time.

The Aetna WorkAbility® website can help!

#### **All you have to do is sign up on the site:**

- Go to [www.aetnadisability.com](http://www.aetnadisability.com)
- Click "Register Now"
- Follow the prompts to create your secure user ID and password

Here are some of the things you may be able to do:

- Print or download forms needed to process your claim
- Check the status of your claims and payments
- Get letters and updates as soon as possible by telling us to send them electronically instead of in the mail - then log in to read them
- Add time to a claim
- Print copies of your benefits pay stubs, or save them to your computer
- Sign up for direct deposit
- Report a return-to-work day so your employer knows when you'll be back
- Contact Aetna at any time via E-mail

(Your employer may not offer all of these options.)

Make it easy on yourself. Start using the WorkAbility® website today. Go to [www.aetnadisability.com](http://www.aetnadisability.com) and select "Register Now."

Aetna Mobile - Find what you need – wherever, whenever



Two ways to download your FREE Aetna Mobile App:

- Text Apps to 44040 to download now\*
- Scan the code with your mobile device

Learn more, visit us at [www.aetna.com/mobile](http://www.aetna.com/mobile)

\*Standard text messaging rates may apply





[[EMAILSUBJECT: Response to your query]]

***PLEASE DO NOT REPLY***

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
10/17/2013

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Leave #: 8864540.

A Short Term Disability introductory letter was mailed to you on October 11, 2013. Please follow the instructions in this letter and have the Authorization to Share and Use Medical Information form and the FML Certification form completed and returned to Aetna in a timely manner.

Your letters and forms are also available for you to view on our website. You may log into your claim and click on the VIEW MY LETTERS tab; then click on the desired letter. Please be sure to disable any pop up blockers on your computer as the letter will open as a pop up.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
**Visit us on the Web: <https://www.aetnadisability.com>**



PO Box 14560  
Lexington, KY 40512-4560  
AKINKAWON TURNER  
STD / LOA Benefit Manager  
Phone: 800-354-1779  
Fax: 1-866-667-1987

01/21/2014

ARTHUR DAVIS

REDACTED

MURFREESBORO TN - 37128

**Employer: Dell Inc**  
**RE: 100% Exhaustion**  
**Claim Number: 8864540**

Dear ARTHUR DAVIS:

Aetna Life Insurance Company ("Aetna") administers leaves for Dell Inc under the Family and Medical Leave Act (FMLA), applicable state law and leave policies of Dell Inc.

This letter is to inform you that you have utilized 100% of the entire allotment for the following entitlement(s):

**Entitlement**  
**Name**

**Date of 100% Exhaustion**

Federal Family and Medical Leave Act (FMLA) 12/31/2013

**Federal Family and Medical Leave Act (FMLA)**

Under the FMLA, except as explained below, eligible employees have a right to leave for the reasons described here. Please note, an employee shall give at least 30 days' notice before the date on which the leave will begin if possible; if the leave is unforeseeable, notice should be provided as soon as is reasonable and practicable.

- A. Up to 12 weeks of unpaid leave in a 12-month period may be approved for the following reasons:
  - 1. Because the employee is unable to perform the functions of his or her job due to his or her own serious health condition;
  - 2. For the care of a spouse, son, daughter, or parent with a serious health condition ('spouse' covers marriages that are recognized in the state where the employee lives);
  - 3. For the birth and care of a newborn child;
  - 4. For placement of a son or daughter with the employee for adoption or foster care; or
  - 5. Due to a qualifying exigency arising out of the employee's spouse, son, daughter, or parent being on active duty, receiving a call to order to active duty in support of a contingency operation, or being deployed to a foreign country
- B. Up to 26 weeks of unpaid leave in a 12-month period may be approved for the following reason:
  - 1. To care for a covered servicemember with a serious injury or illness, if the employee is the spouse, son, daughter, parent, or next of kin of the servicemember.

It is important to understand that any absences after **12/31/2013** and prior to the next entitlement start date are not job-protected under the entitlement(s) listed above.

You should refer to your employee benefits documentation for a detailed description of **Dell Inc** leave policies.

Please contact me at 800-354-1779 with any questions regarding this letter.

Thank you,  
AKINKAWON TURNER  
STD / LOA Benefit Manager



**Chronological Claim Notes:**

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b>	<b>Phone (Mobile)</b>		

The notes are sorted by Task Completed Date when the Task Status is Closed, otherwise they are sorted by the Last Update Date of the Task.

**\*\*\*\* Important Notice \*\*\*\***

**This report is for *Internal Use Only* and contains Protected Health Information (PHI)**

**Internal Aetna Users must adhere to Aetna's Patient Confidentiality standards.**

**For further information please visit: [Aetna's Information Security Statement of Po](#)**

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Run Date: 10/06/2015 4:50:51 am

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Claim Owner Reassignment	2/5/14	Closed	2/5/14 9:49 am	CLAIM TECH USER1 CLAIM TECH USER1	WKAB SYSTEM	WKAB SYSTEM	2/5/14 9:49 am
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Audit information	Claim Owner changed from CLAIM TECH USER1 CLAIM TECH USER1 to MARIBEL AMOR
Prior Owner:	CLAIM TECH USER1 CLAIM TECH USER1
New Owner:	MARIBEL AMOR
Claim Status:	Pend
Date of Change:	2/5/2014
Time of Change:	9:49 AM
Claim Tier:	Tier 3

Internal Worknote	2/5/14	Closed	2/5/14 10:57 am	CAROLE BISHOP	KRISTEN MCQUILLAN	CAROLE BISHOP	2/5/14 10:57 am
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Please enter the internal work note.	Hi Carol,
	LTD claim created.
	Thanks, Kristen

STD to LTD Transition Information Letter	2/5/14	Closed	2/5/14 10:58 am	MARIBEL AMOR	KRISTEN MCQUILLAN	CAROLE BISHOP	2/5/14 10:58 am
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Mailing Method:	USPS
Do Not Send	No
Comments:	

LTD Packet Received	2/5/14	Closed	2/5/14 10:59 am	MARIBEL AMOR	KRISTEN MCQUILLAN	CAROLE BISHOP	2/5/14 10:59 am
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EE Statement Received	2/5/2014
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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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ER Statement Received	2/5/2014
APS Received	2/5/2014
Is additional information needed: (Please check all that apply)	191001 191002 191003 191004 191005
If Other, please specify:	
Proceed with denial for failure to receive appropriate documentation.	
Notes	LTD packet not received. Task closed to explode claim.
Plan of Action	SNR to work with STD DBM and LTD DBM to perfect claim for transition to LTD and to continue to assist LTD DBM with LTD claims processing.

LTD Initial ER Contact - Email	2/5/14	Closed	2/5/14 11:05 am	MARIBEL AMOR	CAROLE BISHOP	MARIBEL AMOR	2/5/14 11:05 am
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To Address List:	US_leave_administrator@dell.com;STD_LOA@aetna.com,SUSAN_PARKER@DELL.COM,
CC Address List:	AmorM@Aetna.com, UngerJ@aetna.com
Do Not Send	No
Comments:	

LTD Claim Assignment	2/5/14	Closed	2/5/14 11:26 am	CAROLE BISHOP	CAROLE BISHOP	CAROLE BISHOP	2/5/14 11:26 am
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Report Date: 10/06/2015

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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#### Case Direction/Return to Work Plan

- Referred to LTD by STD on: 2/5/14
- LTD rec'd: 2/5/14
- STD claim: 8893435
- LTD claim: 9452367
- FDA: 10/9/13
- STD: Plan AA
- LTD: Plan DD
- STD EOB: 4/6/14
- STD WP: 7 days
- LTD WP: 180 days
- LTD date: 4/7/14
- Pre-X: Review if applicable
- Hrs: 40
- Job title/JD:INSIDE SALES ACCOUNT MGMT III, reported as Sedentary. JD in STD claim.
- DOH: 5/55/06
- Dx's: Bilateral RTC tears
- STD currently approved from: 10/9/13-2/13/14
- Claim Hx: EE is a 50 y.o.m. Underwent 10/7/13 Arthroscopy, left shoulder, surgical; with rotator cuff repair; Acromioplasty and Debridement. Surgeon Dr Renfro reported at his 12/13/13 eval that the EE was still doing passive and assisted exercises with therapy following his massive RTC Repair. MD reported the pt is concerned about the level of discomfort. MD reported pain is die to the magnitude of surgery.
- EE, per the Op Report rec'd in the STD claim, just underwent Right shoulder OPEN RTC repair due to another "massive RTC Tear". See the Op report for all procedures performed.

#### ----- DBM Directives:

1. Please continue to work with the STD DBM to perfect claim for transition to LTD.
2. Please confirm eligibility for LTD and review eligibility for effective date, pre-X if applicable, and plan exclusions.
3. Please obtain JD if not done by STD(Was Done, in STD claim).
4. Please complete LTD interview and obtain complete LTD packet from EE.
5. Please develop LTD action plan.
6. Please seek SNR as needed.
7. Please obtain height and wt, if applicable.

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Report Date: 10/06/2015

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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LTD Plan Name	55557
Has Eligibility been confirmed?	No
Load Balance:	Yes
Job Title:	INSIDE SALES ACCOUNT MGMT III
LTD Plan Name	
Triggers:	
CPT Code	29822
CPT Code	29826
CPT Code	29827
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date	10/11/2013 12:00:00 AM
Procedure Date	10/11/2013 12:00:00 AM
Procedure Date	10/11/2013 12:00:00 AM
Hospitalization:	
From	
To	
Estimated Date of Delivery: (if applicable)	
Actual Date of Delivery: (if applicable)	
Tier:	Tier 3

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Report Date: 10/06/2015



Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Claim Owner Reassignment	2/5/14	Closed	2/5/14 11:28 am	CLAIM TECH USER1 CLAIM TECH USER1	WKAB SYSTEM	WKAB SYSTEM	2/5/14 11:29 am
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Audit information  
 Claim Owner changed from CLAIM TECH USER1 CLAIM TECH USER1 to MARIBEL AMOR

Prior Owner:  
 CLAIM TECH USER1 CLAIM TECH USER1

New Owner:  
 MARIBEL AMOR

Claim Status:  
 Pend

Date of Change:  
 2/5/2014

Time of Change:  
 11:28 AM

Claim Tier:  
 Tier 3

Employer Job Description	2/20/14	Closed	2/6/14 3:23 pm	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	2/6/14 3:23 pm
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Please enter the employer job description. I examined the job analysis, the occupation is sedentary. I will ask ER for a job description.

Please enter the employer job description - contd

LTD Claimant Interview	2/14/14	Closed	2/14/14 2:18 pm	MARIBEL AMOR	CAROLE BISHOP	MARIBEL AMOR	2/14/14 2:18 pm
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Completed Contact Type: Employee

If Attorney or "Other"  
 Please define:

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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#### Notes

Initial Documentation of telephonic interview: Claimant Name: Arthur Davis, Claim 9452367, Dell Inc.

-----  
DO YOU HAVE AETNA HEALTH INSURANCE/ who is your carrier?  
Currently I have Aetna COBRA.

HISTORY / ONSET OF CONDITION: If it began prior to the date of disability, or is long standing, what changed to cause them to stop working?  
My shoulder tendons fell off both my right and left shoulder. I was just mowing the lawn and lost full use of my arms. Unfortunately I was struck from behind and now have a Herniated Disc in my back which is causing severe pain along with my shoulder difficulties.

What is your current medical treatment plan?  
I have therapy for my left shoulder two days a week. No therapy scheduled for right shoulder yet. Operation was on January 31st 2014.

Is condition related to work in any way? Did you file a Workers Compensation claim? Name of company and claim adjuster? No, not work related.

Do you have an attorney? Name, address, phone #  
David Clarke of Murfreesboro TN is representing me concerning the back injury.  
(615) 796-6299  
111 North Maple Street, Murfreesboro, TN 37130

Did you have a non-work related injury or a MVA (Motor Vehicle Accident)? If so, how did the accident occur? When was the accident? Where? City and State? Any legal action pending due to orginial injury?  
Was a police report filed? If so, where was it filed? The back injury was a motor vechile accident occurred September 27, 2014. Police report was filed with Murfreesboro TN police department. David Clarke is handling the case.

Restrictions & Limitations ¿ what did your physician advise you to avoid or that you should limit? I have a planned exercise program for my shoulders and back, I just do my therapy. My back problems have limited my activity as well.

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Height and weight: 6 feet 236lbs

Name of all Medical Providers, provide phone and fax number.- How long have you been treating with them? October of 2014 to present. Dr. James Renfro of Premier Orthopedics is treating me strictly for my shoulders. Dr. Christopher Kaufman was treating me for my back. November of 2014 to January 2015. 394 Harding Place. Nashville, TN 37211. Dr Nicholas Cote has taken over current back treatment. I attend therapy 3 times a week for my back. 1272Garrison Drive, Murfreesboro, TN 37129  
Did you discuss your job duties with your provider? Yes

Prescription medications/ what conditions are they prescribed for? I take Celebrex for my back and I have a number of painkillers for my shoulders and back when necessary.

Describe a Typical Day/ ADLs: Back therapy at 9 or 9:30 until 10:30AM. Shoulder therapy at 11AM until 12PM. I come back home.

Any help with household duties? Or shopping? Driving? Yard work? Child or elder care?  
My son helps with any large item shopping. I can do small item shopping. I don't drive a lot, it hurts my back and my shoulders. I hate to admit I have not cleaned my apartment since second surgery. My son lives with his mother, I am responsible for child support.

Volunteer work ¿ where, how often, how many hours? NA

RTW (return to work) Status: Projected Date? What are your plans for work? (or retirement?) Dr. James Renfro is predicting a March return date for shoulders. No ETA concerning my back, very difficult typing this email, both shoulders and back pain.

Duties and Requirements of your Occupation: At least 8-10 hours a day sitting at desk making calls and typing.

Job Status with ER? Are they holding your job? When did you last speak with your supervisor? Dell have offered me a severance package, I have accepted.

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Will they allow part-time or light duty work or provide any accommodations?  
Would you like assistance with RTW? NA

Earnings:  
Your employer indicates your earnings as: \$99,101.30/year. Do you agree? Yes

Retirem  
No

Is the claimant eligible for pension?  
If yes, Pension amount  
Schedule LTD Pension Review task for  
Early Any Occupation Assessment  
Plan of Action

I need the progress notes to assess.  
to send an APS to Dr. Kaufman and Dr. Renfro.

Correspondence - Incoming	2/14/14	Closed	2/14/14 4:40 pm	MARIBEL AMOR	RATNESH KUMAR	MARIBEL AMOR	2/14/14 4:40 pm
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Image Description: ISO

Image Notes:

Pending Info Letter	2/14/14	Closed	2/14/14 10:41 am	MARIBEL AMOR	CAROLE BISHOP	MARIBEL AMOR	2/14/14 10:41 am
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Do Not Send No

Comments:

Faxed Form Request	2/17/14	Closed	2/17/14 9:29 am	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	2/17/14 9:31 am
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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Mailing Method: USPS

Comments:

EE Employment Status	2/18/14	Closed	2/17/14 9:32 am	MARIBEL AMOR	LoadManager	MARIBEL AMOR	2/17/14 9:32 am
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Audit information The client submitted notice of terminated status, please review all open or pended claims.

Faxed Form Request	2/17/14	Closed	2/17/14 9:35 am	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	2/17/14 9:35 am
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Mailing Method: USPS

Comments:

Fax Form Confirmation Task	2/17/14	Closed	2/17/14 9:38 am	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	2/17/14 9:38 am
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Please enter the internal work note.

-----Original Message-----  
 From: Service ID DeliveryWare Fax  
 Sent: Monday, February 17, 2014 9:37 AM  
 To: Amor, Maribel  
 Subject: Job ID 101535694 sent to Dr. Cote; Status (success)

Your fax was successfully sent to Dr. Cote.

Fax number: 615-895-6212  
 Subject: Request for medical information  
 Status: (success)  
 Completed: 9:36:29 AM, Monday, February 17, 2014 Sent pages: 5 of 5  
 Duration: 0:01:27  
 Account: GDV GI DIS CLARITY 2  
 ID: A199265  
 Received CSID: 16158956212  
 JOBID: 101535694

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Fax Form Confirmation Task	2/17/14	Closed	2/17/14 9:39 am	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	2/17/14 9:39 am
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Please enter the internal work note.

-----Original Message-----  
 From: Service ID DeliveryWare Fax  
 Sent: Monday, February 17, 2014 9:38 AM  
 To: Amor, Maribel  
 Subject: Job ID 101536387 sent to Results Physiotherapy; Status (success)

Your fax was successfully sent to Results Physiotherapy.

Fax number: 615-896-6825  
 Subject: Request for PT notes  
 Status: (success)  
 Completed: 9:38:07 AM, Monday, February 17, 2014 Sent pages: 3 of 3  
 Duration: 0:00:42  
 Account: GDV GI DIS CLARITY 2  
 ID: A199265  
 Received CSID: 615 896 6825  
 JOBID: 101536387

Analysis/Review Medical Records	2/17/14	Closed	2/18/14 2:06 pm	MARIBEL AMOR	SANTOSH KUMAR	MARIBEL AMOR	2/18/14 2:06 pm
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Image Description	Analysis/Review Medical Records
Image Notes	
Date Medical Received	02/17/2014
Type of Information Recd-select all that apply	Physical Therapy Notes
If Other Information Received, please describe:	
Provider Name:	Results physiotherapy

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Diagnosis:

If Other, please specify:

CPT Search:

CPT Code

29822

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

Procedure Date:

10/11/2013

Date of Disability:

10/9/2013

RTW Date (if provided):

Notes

Lumbago, and difficulty walking  
presents with irritable low back sacral pain impacting ADL's.

Patient is able to sit for less than a minute before position changed required to secondary to pain.

Plan of Action

to be reviewed by SNR.

CPT Code

29826

CPT Code

29827

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR

Procedure Date:

10/11/2013

Procedure Date:

10/11/2013

LTD Initial Assessment	2/5/14	Closed	2/18/14 2:25 pm	MARIBEL AMOR	CAROLE BISHOP	MARIBEL AMOR	2/18/14 2:25 pm
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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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#### Initial Assessment

Claim received: 02/05/2014  
 LTD determination date: 04/07/2014  
 IHD: No  
 ROI: NO  
 EOB: 07/31/2018  
 Fiduciary/ERISA: ERISA PLAN  
 Control/Plan: 620245 0476626 033 00001 DD 004

Eligibility:  
 Policy effective: 1/1/09  
 Minimum # of hrs: 25  
 Probationary period: First day after 30 days of employment.  
 Contributory: Contributory  
 Pre or post tax: post-tax  
 Elimination period: 180 days  
 Date of hire: 05/22/2006. Info will be verified once paycheck rcvd

Mandatory Rehab: Yes  
 MRBE (source) = Claimant's monthly pre-disability earnings: To be verified  
 Benefit Amount = Actual benefit amount: to be verified.  
 Offsets/FSS/PSS = None at this time  
 FIT/SIT = benefit is taxable  
 Deductions: None at this time  
 ISO = No needed at this time  
 SSD = New case, DBM will advise clmt of ALLSUP services.

Claimant's end of STD benefit: 04/05/2014

Benefit percentage/amount: 60% of monthly pre-disability earnings.  
 Max/min benefit: minimum monthly benefit of \$100.00 or 10% of gross monthly benefit level  
 which ever is greater; maximum monthly benefit is \$10,000  
 Test change/transition: 24 months  
 Forms received to date: none

#### Early Any Occupation Assessment

Will depend on the results of treatment (PT, SP surgery, and medication)

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action

I am currently waiting for eligibility confirmation from Dell.

Interdepartmental Contact	2/18/14	Closed	2/18/14 2:36 pm	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	2/18/14 2:36 pm
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Please enter the interdepartmental contact information.

From: Amor, Maribel  
 Sent: Tuesday, February 18, 2014 2:36 PM  
 To: Turner, Akinkawon  
 Cc: Mcquillan, Kristen J; Bishop, Carole J  
 Subject: Additional impairment and tx sources

RE: Arthur Davis  
 STD 8893435  
 LTD 9452367

Akin,

Claimant also has problems with his back and currently undergoing PT for it. I have updated WKAB with Dr. Cote's information. I have only received the PT notes (see LTD claim). Please request info from Dr. Cote as he seems also impaired from that. Thanks, Maribel

Maribel Amor, MST  
 Senior Disability Benefit Manager  
 Aetna Life Insurance Company  
 Ph: 954-693-2140  
 Fax: 860-907-4494  
 E-mail: AmorM@Aetna.com

Claim summary & pertinent case info

Correspondence - Incoming	2/17/14	Closed	2/18/14 12:21 pm	MARIBEL AMOR	ANIL KUMAR	MARIBEL AMOR	2/18/14 12:21 pm
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Image Description:

treating sources

Image Notes:

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Work History/Education Form	2/20/14	Closed	2/20/14 1:00 pm	MARIBEL AMOR	WEB SERVICE	MARIBEL AMOR	2/20/14 1:00 pm
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Please enter the Image Notes:

Work History/Education Form Status: YES - On File

Work History/Education Form Image #: 14500456

Work History/Education Form Date: 02/11/2014

Do you want to update Voc Rehab screen? Yes

Grade

College

Work History:

Other Income Questionnaire	2/20/14	Closed	2/20/14 1:02 pm	MARIBEL AMOR	WEB SERVICE	MARIBEL AMOR	2/20/14 1:02 pm
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Please enter the Image Notes: One dependent **REDACTED**

Other Income Questionnaire Status: YES - On File

Other Income Questionnaire Image #: 14500453

Other Income Questionnaire Date: 02/11/2014

Do you want to update Forms Screen? Yes

Offsets:

Deductions

Direct Deposit Forms	2/20/14	Closed	2/20/14 1:07 pm	PROD IMAGING_CLIENT ACCOUNTING USER1	WEB SERVICE	ANJISH KHURANA	2/20/14 1:07 pm
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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Enter Image description Notes:

Enter Client Accounting Notes: AK:02/20:Processed.

Medical Authorization Form	2/20/14	Closed	2/20/14 1:10 pm	MARIBEL AMOR	WEB SERVICE	MARIBEL AMOR	2/20/14 1:10 pm
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Please enter the Image Notes: PHI

Medical Release Status: YES - On File

Medical Release Image #:

Date Medical Release Signed 02/11/2014

Do you want to update the Forms tab? Yes

Reimbursement Agreement	2/20/14	Closed	2/20/14 1:11 pm	MARIBEL AMOR	WEB SERVICE	MARIBEL AMOR	2/20/14 1:11 pm
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Image Description:

Image Notes:

Reimbursement Agreement Status: YES - On File

Reimbursement Agreement Image #: 14500450

Reimbursement Agreement Date 02/14/2014

Do you want to update Forms Screen? Yes

Analysis/Review Medical Records	2/20/14	Closed	2/20/14 1:12 pm	MARIBEL AMOR	WEB SERVICE	MARIBEL AMOR	2/20/14 1:12 pm
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Image Description

Image Notes

Date Medical Received 02/20/2014

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Report Date: 10/06/2015

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Type of Information Recd-select all that apply	Other
If Other Information Received, please describe:	DISCLOSURE STATEMENT
Provider Name:	
Diagnosis:	
If Other, please specify:	
CPT Search:	
CPT Code	29822
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
Procedure Date:	10/11/2013
Date of Disability:	10/9/2013
RTW Date (if provided):	
Notes	DISCLOSURE STATEMENT.
Plan of Action	DISCLOSURE STATEMENT.
CPT Code	29826
CPT Code	29827
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

Correspondence - Incoming	2/18/14	Closed	2/20/14 12:57 pm	MARIBEL AMOR	SANTOSH KUMAR	MARIBEL AMOR	2/20/14 12:58 pm
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Image Description: LTD effective 05/22/2006.

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Image Notes:

Medical Authorization Form - FMLA/LOA	2/20/14	Closed	2/20/14 12:59 pm	MARIBEL AMOR	WEB SERVICE	MARIBEL AMOR	2/20/14 12:59 pm
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Please enter the Image Notes: PHI

Medical Release Status: YES - On File

Medical Release Image #:

Date Medical Release Signed: 02/11/2014

Do you want to update the Forms tab? Yes

Financial Authorization	2/20/14	Closed	2/20/14 12:59 pm	MARIBEL AMOR	WEB SERVICE	MARIBEL AMOR	2/20/14 12:59 pm
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Please enter the Image Notes:

Financial Authorization Status: YES - On File

Financial Authorization Image #: 14500451

Financial Authorization Date: 02/11/2014

Do you want to update Forms Screen? Yes

Tax Forms	2/24/14	Closed	2/21/14 8:57 am	MARIBEL AMOR	WEB SERVICE	MARIBEL AMOR	2/21/14 8:57 am
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Enter Image description Notes:

Enter Client Accounting Notes: 02/21:Dk EE's pay group is insured, please provide W4-S form.

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
Faxed Form Request	2/26/14	Closed	2/26/14 1:29 pm	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	2/26/14 1:29 pm

Mailing Method: USPS

Comments:

Fax Form Confirmation Task	2/26/14	Closed	2/26/14 4:44 pm	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	2/26/14 4:44 pm
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Please enter the internal work note.

-----Original Message-----  
 From: Service ID DeliveryWare Fax  
 Sent: Wednesday, February 26, 2014 2:48 PM  
 To: Amor, Maribel  
 Subject: Job ID 102329167 sent to Dr. Renfro; Status (success)

Your fax was successfully sent to Dr. Renfro.

Fax number: 615-834-4722  
 Subject: Request for medical information  
 Status: (success)  
 Completed: 2:48:08 PM, Wednesday, February 26, 2014 Sent pages: 8 of 8  
 Duration: 0:03:02  
 Account: GDV GI DIS CLARITY 2  
 ID: A199265  
 Received CSID: 16158344722  
 JOBID: 102329167

Fax Form Confirmation Task	2/26/14	Closed	2/26/14 4:45 pm	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	2/26/14 4:45 pm
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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Please enter the internal work note.

-----Original Message-----

From: Service ID DeliveryWare Fax  
Sent: Wednesday, February 26, 2014 2:48 PM  
To: Amor, Maribel  
Subject: Job ID 102325943 sent to Dr. Cote; Status (success)

Your fax was successfully sent to Dr. Cote.

Fax number: 615-895-6212  
Subject: Request for medical records  
Status: (success)  
Completed: 2:48:19 PM, Wednesday, February 26, 2014 Sent pages: 5 of 5  
Duration: 0:01:27  
Account: GDV GI DIS CLARITY 2  
ID: A199265  
Received CSID: 16158956212  
JOBID: 102325943

Faxed Form Request	2/26/14	Closed	2/26/14 11:56 am	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	2/26/14 11:56 am
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Mailing Method: USPS

Comments:

Analysis/Review Medical Records	2/27/14	Closed	2/27/14 2:54 pm	MARIBEL AMOR	ROHIT SINGH	MARIBEL AMOR	2/27/14 2:54 pm
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Image Description MED

Image Notes

Date Medical Received 02/27/2014

Type of Information Recd-select all that apply Office/Progress Notes

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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If Other Information Received, please describe:

Provider Name: Dr. Renfro

Diagnosis:

If Other, please specify:

CPT Search:

CPT Code 23420

CPT4 Description RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)

Procedure Date: 1/31/2014

Date of Disability: 10/9/2013

RTW Date (if provided):

Notes He has a massive tear. He is to work on pendulum exercises and passive motion exercises.

On multiple meds

Plan of Action

Has joint pain and night pain  
to obtain the records from Dr. Cote to assess his back and ability to work.

CPT Code 29822

CPT Code 29822

CPT Code 29826

CPT Code 29827

CPT4 Description ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

CPT4 Description ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

CPT4 Description ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

Tax Forms	2/26/14	Closed	2/27/14	7:58 am	PROD IMAGING_CLIENT ACCOUNTING USER1	WEB SERVICE	DEEPAK KUMAR	2/27/14	8:06 am
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Enter Image description Notes:

Enter Client Accounting Notes: 02/27:Dk Withholding amount is not mentioned on the form, Task closed.

LTD Triage Review	3/4/14	Closed	2/27/14	9:43 am	CAROLE BISHOP	CAROLE BISHOP	CAROLE BISHOP	2/27/14	9:43 am
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Claim Owner Present:

Tier: Tier 3

ERTW:

Current Analytics:

Facilitator:

Clinical Resource:

Vocational Resource:

Job Title: INSIDE SALES ACCOUNT MGMT III

Occupation:

Occupational Physical Demand Level:

Rehabilitation: Voluntary

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Disability Definition:

Transition Date: 4/7/2016 12:00:00 AM

Transition Decision Date:

LTD Benefits Begin: 4/7/2014 12:00:00 AM

LTD Benefit End Date: 10/31/2028 12:00:00 AM

Work Related Injury:

WC Benefit Type:

ICD Code Type ICD9

ICD Code Type ICD9

ICD Code Type ICD9

ICD Code 840.4

ICD Code 724.2

ICD Code 719.7

ICD Desc ROTATOR CUFF (CAPSULE) SPRAIN

ICD Desc LUMBAGO

ICD Desc DIFFICULTY IN WALKING

Primary Primary

Primary Secondary

Primary

Effective Date: 10/9/2013 12:00:00 AM

Estimated Delivery:

Actual Delivery:

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
CPT Code				23420			
CPT Code				29822			
CPT Code				29822			
CPT Code				29826			
CPT Code				29827			
CPT4 Description				RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)			
CPT4 Description				ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED			
CPT4 Description				ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED			
CPT4 Description				ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY			
CPT4 Description				ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR			
Procedure Date				1/31/2014 12:00:00 AM			
Procedure Date				10/11/2013 12:00:00 AM			
Procedure Date				1/31/2014 12:00:00 AM			
Procedure Date				10/11/2013 12:00:00 AM			
Procedure Date				10/11/2013 12:00:00 AM			
Last Clinical Review:							
Work Capacity				No Current Work Capacity			

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Triage Review:

2/27/14 LTD SNR Triage Review, CJB, RN

- STD EOB 4/6/14
- LTD start 4/7/14
- Terminated
- Claimant is a 50 y.o.m. Job title is INSIDE SALES ACCOUNT MGMT III, reported as Sedentary. JD in STD claim reports the claimant sits 8 hrs of his 8 hr shift/day, no lifting, reaching, pulling, pushing or over head work. Job entails telephone, computer, desk work.
- DOH: 5/22/06
- Dx's: Massive Bilateral RTC Tears. Claimant underwent 10/11/13: 1. Extensive debridement of left rotator cuff, bursa and labrum. 2. Biceps tenodesis. 3. Open RTC repair including decompression. On 1/31/14 the claimant underwent: 1. Extensive debridement of right labrum and RTC. 2. Subacromial bursa debridement and subacromial decompression. 3. Excision of distal clavicle, separate compartment. 4. Open RTC repair.
- Most recent exam findings submitted, is Orthopedic Surgeon, Dr. Renfro's exam dated 2/11/14 and reports, "F/U of his righr shoulder surgery. Wounds look good. We discussed massive tear with him. He is to work on pendulum exercises and PROM exercises and we will see him back in 1 month.
- MD also reported PMH of: Asthma; DDD Lumbar; HTN; Sciatica; Sprain/Strain, Lumbar; Medial meniscus tear 1/28/14; and S/P Left Knee surgery in 2004.
- Rec'd PT eval dated 1/20/14 for Dx's of Lumbago and Difficulty in walking. Eval reported the claimant has LBP impacting his ADL's, working, sitting and standing. Was unable to assess joint mobility on 1/20/14 secondary to muscle guarding. ROM of spine on 1/20/14 was at 50% on extension; and 75% on flexion with increased pain and left and right side bending. Palpation of lumbosacral region musculature on left and right revealed severe spasms and pain. Claimant was only able to sit for 1 minute before position change required secondary to pain.
- Lastest PT progress note reports the claimant can now sit for 8 minutes before position change required due to pain; Mild spasms and pain along lumbosacral musculature; ROM of lumbar spine is 100%.

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Report Date: 10/06/2015

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan:

LTD DBM Directives:

1. Claim requires Dr. Renfro's March 2014 exam findings. Per LOV on 2/11/14, will be in 4 weeks.
2. DBM has already requested Dr. Cote's exam findings, test results and treatment plan, regarding the claimant's back pain.
3. Claimant reports back pain from an MVA. MVA was not reported during the PT 1/20/14 eval. Is there subrogation?
4. In the future, claimant may require a VRC referral as this EE's job tasks are reported as a PDL of sedentary, and does require prolonged sitting. VRC could evaluate for the appropriateness of an adjustable height workstation, to allow the claimant to change from sitting to standing position as needed, to facilitate RTW.
5. Please request PT's most recent progress note in mid 3/14, for both the shoulders and back.
6. Please alert this SNR once Dr. Renfro's and Dr. Cote's exam findings are rece'd.
7. Please image the JD from STD into LTD claim.

Analysis/Review Medical Records	2/27/14	Closed	2/27/14 10:58 am	MARIBEL AMOR	WEB SERVICE	MARIBEL AMOR	2/27/14 10:58 am
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Image Description

Image Notes

Date Medical Received

02/27/2014

Type of Information Recd-select all that apply

APS

If Other Information Received, please describe:

Provider Name:

Dr. Renfro

Diagnosis:

If Other, please specify:

CPT Search:

CPT Code

23420

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Report Date: 10/06/2015

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT4 Description	RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)
Procedure Date:	1/31/2014
Date of Disability:	10/9/2013
RTW Date (if provided):	
Notes	Dx: Rotator cuff tears, has decreased ROM
	Significant improvement by 05/12/2014
Plan of Action	I will obtain the updated information from Dr. Rengro on 03/11/2014. If enough improvement then I will refer to VR.
CPT Code	29822
CPT Code	29822
CPT Code	29826
CPT Code	29827
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

Triage Directive Acknowledgement	2/27/14	Closed	2/27/14 11:00 am	MARIBEL AMOR	CAROLE BISHOP	MARIBEL AMOR	2/27/14 11:00 am
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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action

Please review this SNR's 2/27/14 LTD Triage review. I will obtain Dr. Renfro's evaluation on 03/11/2014 and Dr. Cote's for his back problem.

Email Response to Member	3/6/14	Closed	3/6/14 1:37 pm	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	3/6/14 1:37 pm
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To Address List:

**REDACTED**

CC Address List:

AmorM@Aetna.com

Do Not Send

No

Comments:

Correspondence - Incoming	3/7/14	Closed	3/7/14 3:23 pm	MARIBEL AMOR	KUNAL CHAWLA	MARIBEL AMOR	3/7/14 3:23 pm
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Image Description:

EMAIL from claimant stating that he will request the medical records from Dr. Cote.

Image Notes:

Faxed Form Request	3/7/14	Closed	3/7/14 4:50 pm	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	3/7/14 4:50 pm
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Mailing Method:

USPS

Comments:

Fax Form Confirmation Task	3/7/14	Closed	3/7/14 4:56 pm	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	3/7/14 4:56 pm
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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Please enter the internal work note.

-----Original Message-----

From: Service ID DeliveryWare Fax  
Sent: Friday, March 07, 2014 4:55 PM  
To: Amor, Maribel  
Subject: Job ID 103098955 sent to Dr. Green; Status (success)

Your fax was successfully sent to Dr. Green.

Fax number: 615-867-7974  
Subject: Request for medical evidence  
Status: (success)  
Completed: 4:54:31 PM, Friday, March 07, 2014 Sent pages: 5 of 5  
Duration: 0:02:50  
Account: GDV GI DIS CLARITY 2  
ID: A199265  
Received CSID: 16158677974  
JOBID: 103098955

Analysis/Review Medical Records	3/12/14	Closed	3/13/14 12:25 pm	MARIBEL AMOR	WEB SERVICE	MARIBEL AMOR	3/13/14 12:25 pm
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Image Description

Image Notes

Date Medical Received 03/12/2014

Type of Information Recd-select all that apply 200001|200005

If Other Information Received, please describe: CLW

Provider Name:

Diagnosis:

If Other, please specify:

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Report Date: 10/06/2015



Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT Search:

CPT Code

23420

CPT4 Description

RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)

Procedure Date:

1/31/2014

Date of Disability:

10/9/2013

RTW Date (if provided):

Notes

DX: ROTATOR CUFF TEAR, LEFT  
ROTATOR CUFF TEAR, RIGHT  
MENISCUS TEARS LEFT KNEE  
HEIGHT: 6' 0", WEIGHT 235 LBS.

SYMPTOMS: PAIN, DECREASED MOTION OF BOTH ARMS

NO ABILITY TO WORK  
"NO USE OF BILATERAL UPPER EXTREMITIES"

Plan of Action

TO BE REVIEWED BY SNR. IT SEEMS THAT IF CLAIMANT HAS NO USE OF BILATERAL UPPER EXTREMITIES THEN HE WILL NO BE ABLE TO DO HIS SEDENTARY LEVEL WORK. I WILL ASK FOR VOCATIONAL INPUT.

CPT Code

29822

CPT Code

29822

CPT Code

29826

CPT Code

29827

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

Correspondence - Incoming	3/13/14	Closed	3/14/14 11:40 am	MARIBEL AMOR	PABITRA SARKAR	MARIBEL AMOR	3/14/14 11:40 am
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Image Description:	1st evaluation with pain mgt 04/02/2014
Image Notes:	

Analysis/Review Medical Records	3/12/14	Closed	3/14/14 11:46 am	MARIBEL AMOR	KAPIL SINGH	MARIBEL AMOR	3/14/14 11:46 am
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Image Description	PROGRESS NOTE
Image Notes	
Date Medical Received	03/12/2014
Type of Information Recd-select all that apply	Office/Progress Notes
If Other Information Received, please describe:	
Provider Name:	Dr. Renfro
Diagnosis:	
If Other, please specify:	
CPT Search:	
CPT Code	23420

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT4 Description	RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)
Procedure Date:	1/31/2014
Date of Disability:	10/9/2013
RTW Date (if provided):	
Notes	<p>CC: Right shoulder, left knee</p> <p>Claimant is going to have left knee surgery in approximately 4 weeks.</p> <p>ROS: muscular weakness, incoordination, tingling or numbness, loss of balance</p> <p>next f/u within 4 weeks</p>
Plan of Action	to monitor for knee surgery. If knee surgery, claimant will need LTD. Also claimant is unable to use UE's which is critical to most sedentary work. I will discuss with SNR.
CPT Code	29822
CPT Code	29822
CPT Code	29826
CPT Code	29827
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Procedure Date: 10/11/2013

Analysis/Review Medical Records	3/13/14	Closed	3/14/14 11:48 am	MARIBEL AMOR	WEB SERVICE	MARIBEL AMOR	3/14/14 11:48 am
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Image Description

Image Notes

Date Medical Received 03/13/2014

Type of Information Recd-select all that apply APS

If Other Information Received, please describe:

Provider Name:

Diagnosis:

If Other, please specify:

CPT Search:

CPT Code 23420

CPT4 Description RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)

Procedure Date: 1/31/2014

Date of Disability: 10/9/2013

RTW Date (if provided):

Notes Blank form received.

Plan of Action to continue the LTD process.

CPT Code 29822

CPT Code 29822

CPT Code 29826

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT Code	29827
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

LTD Follow Up Clinical Review	3/12/14	Closed	3/18/14	3:14 pm	CAROLE BISHOP	CAROLE BISHOP	CAROLE BISHOP	3/18/14	3:14 pm
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STD Benefits End:	4/6/2014 12:00:00 AM
LTD Benefits Begin:	4/7/2014 12:00:00 AM
LTD Determination Date:	

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Assessment:

- 3/18/14 LTD SNR FOLLOW-UP CJB, RN
- Last SNR F/U 2/27/14
- STD EOB 4/6/14
- LTD start 4/7/14
- EE was Terminated
- Claimant is a 50 y.o.m. Job title is INSIDE SALES ACCOUNT MGMT III, reported as Sedentary. JD in STD claim reports the claimant sits 8 hrs of his 8 hr shift/day, no lifting, reaching, pulling, pushing or over head work. Job entails telephone, computer, desk work.
- DOH: 5/22/06
- Dx's: Massive Bilateral RTC Tears. Claimant underwent 10/11/13: 1. Extensive debridement of left rotator cuff, bursa and labrum. 2. Biceps tenodesis. 3. Open RTC repair including decompression. On 1/31/14 the claimant underwent: 1. Extensive debridement of right labrum and RTC. 2. Subacromial bursa debridement and subacromial decompression. 3. Excision of distal clavicle, separate compartment. 4. Open RTC repair.
- Submitted for this review was an APS dated 2/28/14 and signed by Orthopedic MD, Dr. Renfro reporting EE disabled from 10/11/13 ending on 5/12/14. Dx of L RTC Tear, R RTC Tear, and L Meniscus Tears. Underwent the shoulder surgeries as reported above. Wt 235lbs, 6' tall. Meds.: Percocet and Toradol prn. LOV was 2/11/14, NOV 3/11/14, and seen monthly. Has pain and decreased ROM of both arms. No Use of bil UE's. MD reported the EE id motivated to RTW.
- Dr. Renfro completed another APS, not dated; reporting NOV 3/11/14 and 5/12/1`4 reported as RTW. MD only reported about the bil. RTC repairs, and reported about surgery at Premier Ortho. Surgery Ctr, but not sure if the MD is reporting that is where the EE had his shoulder surgeries, or is reporting that is where the L Knee surgery will be done.
- Submitted was Dr. Renfro's CL&W, dated 3/11/14, reporting the EE is never able to perform any of the listed tasks and the NOV is 4/25/14.
- Submitted was Dr. Renfro's 3/11/14 eval reporting the EE is 6 weeks post-op L RTC Repair. EE requesting to schedule L Knee meniscus tears repairs in 4 weeks. Can start a Light strengthening program now with R shoulder in PT, and f/u in 4 weeks.
- PT notes submitted in STD claim. Most recent 2/18/14 reporting, "No significant change in LUE from previous vs. Is able to reach behind back w more ROM than last week. Pt reports weakness and overhead activities still difficult. A 2/13/14 PT note reported, "Plan to continue PT on L shoulder for remaining 2 weeks. PT recommends continued therapy on L shoulder for 2x/wk x 4 wks or until pt sees MD in March for RUE F/U. MD reports to hold off on RUE PROM and therapy at this time until further f/u."

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Report Date: 10/06/2015

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Checked medical systems?	Not Applicable
Will you make a referral to Vocation Rehabilitation?	No
If No, select reason:	Not appropriate at this time
Will you make a referral to BHU?	
Work Capacity	Unclear Work Capacity - TBD
Recommendations:	<ul style="list-style-type: none"> <li>- LTD DBM DIRECTIVES:</li> <li>- The LTD start date is 4/7/14. However, this SNR cannot recommend LTD approval at this time. The EE did have 2 Open RTC Repairs that were reported as extensive. However, he has a sedentary job, and per the JD submitted by the employer, the EE sits 8 hrs of his 8 hr shift/day, no lifting, reaching, pulling, pushing or over head work. Job entails telephone, computer, desk work.</li> <li>- To review claim further need date of Dr. Renfro's NOV confirmed. Is it 3/31/14 or 4/25/14? Need date of L knee surgery. Need Pain Management evaluation reportedly to occur on 4/2/14.</li> <li>- STD and LTD are working together as STD is only approved through 3/11/14, with STD EOB of 4/6/14.</li> <li>- Once the imposed questions are answered, please notify this SNR.</li> <li>- OF NOTE: CLAIM IS BEING PRESENTED AT THE SCD MEETING ON 3/20/14.</li> <li>- SNR will set a f/u task for 3/25/14</li> </ul>
Do you want to generate an LTD Follow up Clinical Review task?	
If yes, LTD Follow Up Clinical Review Task Date:	

Employer Contact Email	3/18/14	Closed	3/18/14	3:30 pm	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	3/18/14	3:30 pm
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To Address List:	SUSAN_PARKER@DELL.COM
CC Address List:	AmorM@aetna.com
Do Not Send	No
Comments:	

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Faxed Form Request	3/18/14	Closed	3/18/14 4:23 pm	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	3/18/14 4:23 pm
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Mailing Method: USPS

Comments:

Clinical Review Acknowledgement	3/18/14	Closed	3/18/14 4:30 pm	MARIBEL AMOR	CAROLE BISHOP	MARIBEL AMOR	3/18/14 4:30 pm
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Recommendations:

- LTD DBM DIRECTIVES:
- The LTD start date is 4/7/14. However, this SNR cannot recommend LTD approval at this time. The EE did have 2 Open RTC Repairs that were reported as extensive. However, he has a sedentary job, and per the JD submitted by the employer, the EE sits 8 hrs of his 8 hr shift/day, no lifting, reaching, pulling, pushing or over head work. Job entails telephone, computer, desk work.
- To review claim further need date of Dr. Renfro's NOV confirmed. Is it 3/31/14 or 4/25/14? Need date of L knee surgery. Need Pain Management evaluation reportedly to occur on 4/2/14.
- STD and LTD are working together as STD is only approved through 3/11/14, with STD EOB of 4/6/14.
- Once the imposed questions are answered, please notify this SNR.
- OF NOTE: CLAIM IS BEING PRESENTED AT THE SCD MEETING ON 3/20/14.
- SNR will set a f/u task for 3/25/14

Plan of Action:

- 1) Requested a full job description as of all jobs might require some level of reaching
- 2) Confirmed that claimant will have surgery April 18, 2014 by Dr. Renfro
- 3) Currently undergoing PT, will request the latest notes
- 4) Sent the last request to Dr. Cote/orthopedic surgeon to determine how the back pain will prevent him from performing his job duties as an inside sales representative? I also sent an e-mail to claimant to notify him that I have not received the medical records although he signed a release of information.

Email Response to Member	3/18/14	Closed	3/18/14 4:37 pm	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	3/18/14 4:37 pm
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Report Date: 10/06/2015



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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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To Address List: **REDACTED**

CC Address List: AmorM@aetna.com

Do Not Send: No

Comments:

Fax Form Confirmation Task	3/18/14	Closed	3/18/14 4:49 pm	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	3/18/14 4:49 pm
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Please enter the internal work note.

Original Message-----  
 From: Service ID DeliveryWare Fax  
 Sent: Tuesday, March 18, 2014 4:49 PM  
 To: Amor, Maribel  
 Subject: Job ID 103842264 sent to Dr. Cote; Status (success)

Your fax was successfully sent to Dr. Cote.

Fax number: 615-895-6212  
 Subject: Request for medical records  
 Status: (success)  
 Completed: 4:48:44 PM, Tuesday, March 18, 2014 Sent pages: 3 of 3  
 Duration: 0:00:43  
 Account: GDV GI DIS CLARITY 2  
 ID: A199265  
 Received CSID: 16158956212  
 JOBID: 103842264

IHD Consent Letter	3/18/14	Closed	3/18/14 5:13 pm	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	3/18/14 5:14 pm
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Mailing Method: USPS

Do Not Send: No

Comments:

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Report Date: 10/06/2015

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Faxed Form Request	3/18/14	Closed	3/18/14 5:18 pm	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	3/18/14 5:18 pm
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Mailing Method: USPS

Comments:

Fax Form Confirmation Task	3/18/14	Closed	3/19/14 8:45 am	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	3/19/14 8:45 am
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Please enter the internal work note.

-----Original Message-----

From: Service ID DeliveryWare Fax

Sent: Tuesday, March 18, 2014 5:21 PM

To: Amor, Maribel

Subject: Job ID 103850386 sent to Murfreesboro Results Physiotherapy; Status (success)

Your fax was successfully sent to Murfreesboro Results Physiotherapy.

Fax number: 615-896-6825

Subject: Request for physical therapy notes

Status: (success)

Completed: 5:21:09 PM, Tuesday, March 18, 2014 Sent pages: 3 of 3

Duration: 0:00:39

Account: GDV GI DIS CLARITY 2

ID: A199265

Received CSID: 615 896 6825

JOBID: 103850386

Correspondence - Incoming	3/18/14	Closed	3/19/14 8:46 am	MARIBEL AMOR	PABITRA SARKAR	MARIBEL AMOR	3/19/14 8:46 am
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Image Description: Praxis referral

Image Notes:

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Financial Worknote	3/20/14	Closed	3/19/14 12:16 pm	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	3/19/14 12:18 pm
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Notes

Received payroll information from Dell.

Base salary: \$44,388.49  
 Commissions: \$19,023.64  
 Income: \$62,412.13  
 monthly salary: \$5,284.34 x 60%= \$3,179.61

Once, I receive the records from Dr. Cote to address the back issue and the PT notes I will be able to render a determination.

Plan of Action

Faxed Form Request	3/20/14	Closed	3/20/14 1:12 pm	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	3/20/14 1:12 pm
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Mailing Method:

USPS

Comments:

Correspondence - Incoming	3/19/14	Closed	3/20/14 1:16 pm	MARIBEL AMOR	KUNAL CHAWLA	MARIBEL AMOR	3/20/14 1:16 pm
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Image Description:

PAYSTUBS

Image Notes:

Employer Contact Email	3/20/14	Closed	3/20/14 1:26 pm	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	3/20/14 1:26 pm
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To Address List:

US\_leave\_administrator@dell.com,STD\_LOA@aetna.com,SUSAN\_PARKER@DELL.COM,

CC Address List:

AmorM@aetna.com

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Do Not Send No

Comments:

Financial Worknote	3/21/14	Closed	3/20/14 3:03 pm	AMANDA FERRANTE	AMANDA FERRANTE	AMANDA FERRANTE	3/20/14 3:03 pm
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Notes

Aetna has referred this claim to Praxis for investigation of WC/TPL. Please contact Alison Stackpole at 765.216.0240 or alison.stackpole@praxisconsulting.com if you have any questions.

Praxis has accepted the referral and is pursuing on behalf of Aetna.

Plan of Action

Correspondence - Incoming	3/19/14	Closed	3/20/14 11:50 am	MARIBEL AMOR	ANKESH KUMAR	MARIBEL AMOR	3/20/14 11:50 am
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Image Description: Payroll requested

Image Notes:

Analysis/Review Medical Records	3/19/14	Closed	3/20/14 11:55 am	MARIBEL AMOR	KAPIL SINGH	MARIBEL AMOR	3/20/14 11:55 am
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Image Description: OV NOTE

Image Notes

Date Medical Received 03/19/2014

Type of Information Recd-select all that apply Physical Therapy Notes

If Other Information Received, please describe:

Provider Name:

Diagnosis:

If Other, please specify:

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT Search:

CPT Code

23420

CPT4 Description

RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)

Procedure Date:

1/31/2014

Date of Disability:

10/9/2013

RTW Date (if provided):

Notes

PT notes.

Claimant continues to have subjective complaints of pain.

Plan of Action

Claimant has been referred to physiatrist for continued pain mgt. First visit 04/02/2014. To be reviewed by SNR.

CPT Code

29822

CPT Code

29822

CPT Code

29826

CPT Code

29827

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR

Procedure Date:

10/11/2013

Procedure Date:

1/31/2014

Procedure Date:

10/11/2013

Procedure Date:

10/11/2013

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Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Email Response to Member	3/26/14	Closed	3/26/14 10:08 am	SHERRI MCINNES	SHERRI MCINNES	SHERRI MCINNES	3/26/14 10:08 am
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To Address List:

**REDACTED**

CC Address List:

Do Not Send

No

Comments:

Email From Member	3/25/14	Closed	3/26/14 10:08 am	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	SHERRI MCINNES	3/26/14 10:08 am
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Member Home Email Address

**REDACTED**

Date and Time Submitted

3/25/2014 7:41:06 PM

Question Category selected

My LTD Claim Details

Question Submitted

I am writing to ensure that my emails, medical records and information have been received by Maribel.

Plan of Action

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

We have received all necessary paperwork for the claim. Your Claim Manager will send you a confirmation letter with the details about your claim, once the review has been completed.

Please let us know if we can provide additional assistance.

Inquiry Analysis:

Claim status

Details of Inquiry:

Response Analysis:

Customer Service response

Details of Response:

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Response Method: Reply via email

Analysis/Review Medical Records	3/25/14	Closed	3/28/14 1:04 pm	MARIBEL AMOR	SANTOSH KUMAR	MARIBEL AMOR	3/28/14 1:04 pm
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Image Description	Analysis/Review Medical Records
Image Notes	
Date Medical Received	03/25/2014
Type of Information Recd-select all that apply	Office/Progress Notes
If Other Information Received, please describe:	
Provider Name:	Dr. Cote
Diagnosis:	
If Other, please specify:	
CPT Search:	
CPT Code	23420
CPT4 Description	RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)
Procedure Date:	1/31/2014
Date of Disability:	10/9/2013
RTW Date (if provided):	
Notes	<p>MRI showed multilevel disc bulges with no spinal canal stenois, multilevel facet joint/ligamentum flavum hypertrophy, etc.</p> <p>On multiple meds for sleep and also pain.</p> <p>Height is 72 inches, weight is 239 lbs.</p>

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action	STD submitted claim for PMR peer. I will attempt to get the medical records from pain mgt.
CPT Code	29822
CPT Code	29822
CPT Code	29826
CPT Code	29827
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

Medical Authorization Form	3/19/14	Closed	3/28/14	1:05 pm	MARIBEL AMOR	ANIL KUMAR	MARIBEL AMOR	3/28/14	1:05 pm
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Please enter the Image Notes: MED

Medical Release Status: NO - REVOKED

Medical Release Image #:

Date Medical Release Signed

Do you want to update the Forms tab?

Analysis/Review Medical Records	3/21/14	Closed	3/28/14	1:10 pm	MARIBEL AMOR	ANIL KUMAR	MARIBEL AMOR	3/28/14	1:10 pm
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Report Date: 10/06/2015



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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Image Description

Image Notes

Date Medical Received

03/21/2014

Type of Information Recd-select all that apply

Physical Therapy Notes

If Other Information Received, please describe:

Provider Name:

Diagnosis:

If Other, please specify:

CPT Search:

CPT Code

23420

CPT4 Description

RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)

Procedure Date:

1/31/2014

Date of Disability:

10/9/2013

RTW Date (if provided):

Notes

Patient at high functioning level with no compensation but continues to have high subjective c/o of pain.

Plan of Action

to be reviewed by SNR. A PM&R pending (STD)

CPT Code

29822

CPT Code

29822

CPT Code

29826

CPT Code

29827

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

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Report Date: 10/06/2015

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

Analysis/Review Medical Records	3/19/14	Closed	3/28/14	1:26 pm	MARIBEL AMOR	ANIL KUMAR	MARIBEL AMOR	3/28/14	1:26 pm
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Image Description

Image Notes

Date Medical Received: 03/19/2014

Type of Information Recd-select all that apply: 200002|200003

If Other Information Received, please describe:

Provider Name: Dr. Cote

Diagnosis:

If Other, please specify:

CPT Search:

CPT Code: 23420

CPT4 Description: RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)

Procedure Date: 1/31/2014

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Date of Disability:	10/9/2013
RTW Date (if provided):	
Notes	duplicate medical record
Plan of Action	N/A
CPT Code	29822
CPT Code	29822
CPT Code	29826
CPT Code	29827
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

LTD Follow Up Clinical Review	3/25/14	Closed	3/28/14	3:42 pm	CAROLE BISHOP	CAROLE BISHOP	CAROLE BISHOP	3/28/14	3:42 pm
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STD Benefits End:	4/6/2014 12:00:00 AM
LTD Benefits Begin:	4/7/2014 12:00:00 AM
LTD Determination Date:	

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Assessment:

3/28/14 LTD SNR F/U CJB, RN

- Last SNR F/U 3/18/14
- STD EOB 4/6/14
- LTD start 4/7/14
- EE was Terminated
- Claimant is a 50 y.o.m. Job title is INSIDE SALES ACCOUNT MGMT III, reported as Sedentary. JD in STD claim reports the claimant sits 8 hrs of his 8 hr shift/day, no lifting, reaching, pulling, pushing or overhead work. Job entails telephone, computer, desk work.
- DOH: 5/22/06
- This SNR reported: - Dx's: Massive Bilateral RTC Tears. Claimant underwent 10/11/13: 1. Extensive debridement of left rotator cuff, bursa and labrum. 2. Biceps tenodesis. 3. Open RTC repair including decompression. On 1/31/14 the claimant underwent: 1. Extensive debridement of right labrum and RTC. 2. Subacromial bursa debridement and subacromial decompression. 3. Excision of distal clavicle, separate compartment. 4. Open RTC repair.
- Submitted for this review was an APS dated 2/28/14 and signed by Orthopedic MD, Dr. Renfro reporting EE disabled from 10/11/13 ending on 5/12/14. Dx of L RTC Tear, R RTC Tear, and L Meniscus Tears. Underwent the shoulder surgeries as reported above. Wt 235lbs, 6' tall. Meds.: Percocet and Toradol prn. LOV was 2/11/14, NOV 3/11/14, and seen monthly. Has pain and decreased ROM of both arms. No Use of bil UE's. MD reported the EE id motivated to RTW.
- Dr. Renfro completed another APS, not dated; reporting NOV 3/11/14 and 5/12/1`4 reported as RTW. MD only reported about the bil. RTC repairs, and reported about surgery at Premier Ortho. Surgery Ctr, but not sure if the MD is reporting that is where the EE had his shoulder surgeries, or is reporting that is where the L Knee surgery will be done.
- Submitted was Dr. Renfro's CL&W, dated 3/11/14, reporting the EE is never able to perform any of the listed tasks and the NOV is 4/25/14.
- Submitted was Dr. Renfro's 3/11/14 eval reporting the EE is 6 weeks post-op L RTC Repair. EE requesting to schedule L Knee meniscus tears repairs in 4 weeks. Can start a Light strengthening program now with R shoulder in PT, and f/u in 4 weeks.
- PT notes submitted in STD claim. Most recent 2/18/14 reporting, "No significant change in LUE from previous vs. Is able to reach behind back w more ROM than last week. Pt reports weakness and overhead activities still difficult. A 2/13/14 PT note reported, "Plan to continue PT on L shoulder for remaining 2 weeks. PT recommends continued therapy on L shoulder for 2x/wk x 4 wks or until pt sees MD in March for RUE F/U. MD reports to hold off on RUE PROM and therapy at this time until further f/u."

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Report Date: 10/06/2015

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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<p>Checked medical systems?</p> <p>Will you make a referral to Vocation Rehabilitation?</p> <p>If No, select reason:</p> <p>Will you make a referral to BHU?</p> <p>Work Capacity</p> <p>Recommendations:</p>  <p>Do you want to generate an LTD Follow up Clinical Review task?</p> <p>If yes, LTD Follow Up Clinical Review Task Date:</p>	<p>-----For this review rec'd 11/8/13 MRI L-spine from Dr. Cote reporting, "1. Multilevel disc bulges w no spinal canal stenosis. 2. Multilevel facet jt/ligamentum flavum hypertrophy, w R neyral foraminal narrowing at L4-L5, mild L neural narrowing at L5-S1. 3. Mild DDD at L3-L4. Rec;d Dr Cote's 1/16/14 Initial Exam reporting MS: Inspection/palpation of jts, bones, and muscles normal. Normal ROM. Normal muscle strength and tone. LS Spine : Appearance normal, pain at bil. SI jts, some tenderness. LE tewsting normal bil. Hip strength normal bil. DTR 2/4bil. Assessment LBP; Benign Esst. HTN; GERD; Intervertebral DD; Somatic dsyfunction SI region; Asthma. 1/28/14 eval w Dr Cote LBP and assessment of normal gait and station, LBP somatic dysfunction of rib cage, pelvic region, lumbar and thoracic regions. 3/6/14 Dr. Cote eval did not report any deficits on exam, but concluded that back pain is persistent and disrupting pts life. Will refer for further eval and tx. Cont. PTas it is helping.</p> <p>Not Applicable</p> <p>No</p> <p>RTW in place</p> <p>No</p> <p>Unclear Work Capacity - TBD</p> <p>- LTD DBM DIRECTIVES:</p> <p>- The LTD start date is 4/7/14. However, this SNR cannot recommend LTD approval at this time. Claim was presented to the SCD Meeting on 3/27/14 by STD. It was decided that this claim requires a PR to determine the EE's functionality beyond STD EOB of 4/6/14, as it was also decided to extend the STD claim through the STD EOB secondary to the need of a PR.</p> <p>- Once the PR is submitted, please alert this SNR, as LTD clinical determination will be based on the PR decision.</p> <p>Yes</p> <p>4/10/2014</p>
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Analysis/Review Medical Records	3/20/14	Closed	3/28/14 4:47 pm	MARIBEL AMOR	PAWAN KUMAR	MARIBEL AMOR	3/28/14 4:47 pm
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Image Description	MED DOC
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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Image Notes

Date Medical Received

03/20/2014

Type of Information Recd-select all that apply

Physical Therapy Notes

If Other Information Received, please describe:

Provider Name:

Diagnosis:

If Other, please specify:

CPT Search:

CPT Code

23420

CPT4 Description

RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)

Procedure Date:

1/31/2014

Date of Disability:

10/9/2013

RTW Date (if provided):

Notes

already reviewed by SNR

Plan of Action

will wait for the peer review ordered by STD.

CPT Code

29822

CPT Code

29822

CPT Code

29826

CPT Code

29827

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

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Report Date: 10/06/2015

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

Clinical Review Acknowledgement	3/28/14	Closed	3/28/14 4:51 pm	MARIBEL AMOR	CAROLE BISHOP	MARIBEL AMOR	3/28/14 4:51 pm
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Recommendations:	<ul style="list-style-type: none"> <li>- LTD DBM DIRECTIVES:</li> <li>- The LTD start date is 4/7/14. However, this SNR cannot recommend LTD approval at this time. Claim was presented to the SCD Meeting on 3/27/14 by STD. It was decided that this claim requires a PR to determine the EE's functionality beyond STD EOB of 4/6/14, as it was also decided to extend the STD claim through the STD EOB secondary to the need of a PR.</li> <li>- Once the PR is submitted, please alert this SNR, as LTD clinical determination will be based on the PR decision.</li> </ul>
Plan of Action:	PR was requested by STD.

Analysis/Review Medical Records	3/20/14	Closed	3/28/14 5:01 pm	MARIBEL AMOR	ANIL KUMAR	MARIBEL AMOR	3/28/14 5:02 pm
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Image Description	DR NTOE
Image Notes	
Date Medical Received	03/20/2014
Type of Information Recd-select all that apply	Physical Therapy Notes
If Other Information Received, please describe:	
Provider Name:	

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Diagnosis:

If Other, please specify:

CPT Search:

CPT Code

23420

CPT4 Description

RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)

Procedure Date:

1/31/2014

Date of Disability:

10/9/2013

RTW Date (if provided):

Notes

PT of the shoulders.

Plan of Action

to wait for the peer review.

CPT Code

29822

CPT Code

29822

CPT Code

29826

CPT Code

29827

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR

Procedure Date:

10/11/2013

Procedure Date:

1/31/2014

Procedure Date:

10/11/2013

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Report Date: 10/06/2015



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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Procedure Date: 10/11/2013

Faxed Form Request	4/3/14	Closed	4/3/14 9:47 am	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	4/3/14 9:47 am
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Mailing Method: USPS  
Comments:

STD-LTD Extension	4/4/14	Closed	4/3/14 10:06 am	MARIBEL AMOR	CAROLE BISHOP	MARIBEL AMOR	4/3/14 10:06 am
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Mailing Method: USPS  
Do Not Send No  
Comments:

Fax Form Confirmation Task	4/3/14	Closed	4/3/14 10:08 am	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	4/3/14 10:08 am
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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Please enter the internal work note.

-----Original Message-----  
 From: Service ID DeliveryWare Fax  
 Sent: Thursday, April 03, 2014 9:53 AM  
 To: Amor, Maribel  
 Subject: Job ID 105066803 sent to Dr. Brenna Green; Status (success)

Your fax was successfully sent to Dr. Brenna Green.

Fax number: 615-867-7974  
 Subject: Request for medical information  
 Status: (success)  
 Completed: 9:52:39 AM, Thursday, April 03, 2014 Sent pages: 5 of 5  
 Duration: 0:02:50  
 Account: GDV GI DIS CLARITY 2  
 ID: A199265  
 Received CSID: 16158677974  
 JOBID: 105066803

Internal Worknote	4/11/14	Closed	4/11/14 10:24 am	MARIBEL AMOR	MARIBEL AMOR	MARIBEL AMOR	4/11/14 11:26 am
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Please enter the internal work note.

I confirmed with STD that the peer review has not been completed.

LTD Follow Up Clinical Review	4/17/14	Closed	4/22/14 11:25 am	TAYLOR SMITH JR	CAROLE BISHOP	TAYLOR SMITH JR	4/22/14 11:25 am
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STD Benefits End: 4/6/2014 12:00:00 AM

LTD Benefits Begin: 4/7/2014 12:00:00 AM

LTD Determination Date:

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Assessment:	4/11/14- Emailed STD DBM for an update on the PR determination, as this LTD SNR did not see a PR determination in the STD claim, as this LTD claim start is contingent on the PR determination started in STD. - STD DBM responded no PR determination yet. Will f/u.
Checked medical systems?	Not Applicable
Will you make a referral to Vocation Rehabilitation?	No
If No, select reason:	Not appropriate at this time
Will you make a referral to BHU?	No
Work Capacity	Unclear Work Capacity - TBD

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Recommendations:

STD HISTORY: no previous claims  
 FMLA HISTORY: no previous claims  
 FDA: 10/9/2013  
 EE CURRENTLY APPROVED: 10/9/2013-2/13/2014

EE JOB TITLE/CLASSIFICATION: Inside Sales Acct Mgmt, SEDENTARY occupation  
 - J/D in claim  
 - No push, pull, lift, overhead work  
 EE CO-MORBIDS: Diabetes, HTN, GERD

EE DIAGNOSIS: rotator cuff repair on 10/11/2013 and 1/31/14

MDA GUIDELINES:  
 - 7/10/42  
 - MIN MDA: 10/16/2013  
 - OPT MDA: 10/19/2013  
 - MAX MDA: 11/19/2013  
 - EE currently approved 128 days into STD benefits, outside of mda guidelines for procedure/occ.  
 BHU INVOLVEMENT: none  
 VOCATIONAL REHAB INVOLVEMENT: none  
 IHD CONSENT ON FILE: EE does not have Aetna insurance  
 REVIEW OF MEDICAL SYSTEMS: n/a

REVIEW OF RECENT MEDICALS IN CLAIM:  
 Most recent APS states the following:  
 - EE slow to progress with therapy  
 - LOV 11/15/2013  
 - NOV 12/13/2013  
 - RTW: 1/14/2013  
 - EE to continue PT 2-3 times per week  
 - EE to have same surgery on opposite shoulder once he is healed from this surgery.

EE had PT/Office visit on 11/15/2013:  
 - EE having decreased shoulder pain, increase low back pain

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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- rom values affected shoulder: flexion 125 (normal 180), abduction 80 (normal 150), external rotation 40 (normal 40-60), internal rotation 50 (normal 90)
- passive shoulder rom is severely impaired
- EE has improved his rom values since surgery
- decreased lumbar rom on exam
- plan: continue PT, follow up with provider one month

EE had OV 12/13/2013:

- continue to c/o discomfort
- EE has been doing passive & assisted exercise with therapy
- shoulder ROM: rom values affected shoulder: flexion 127 (normal 180), abduction 90 (normal 150), external rotation 55 (normal 40-60), internal rotation 57 (normal 90)
- plan: progress to active therapy program and light strength, follow up in one month

EE had right rotator cuff repair on 1/31/2014.

MDA guidelines from 1/31/2014 surgery date:  
 7/10/42  
 min mda: 2/6/2014  
 opt mda: 2/9/2014  
 max mda: 3/13/2014

EE had OV 2/11/2014:

- EE had sutures removed, continue sling
- work on pendulum exercises and passive rom in therapy
- NOV 3/11/2014

EE is not released to rtw for 3 months.

EE has been terminated on 2/7/2014 from Dell.

EE has open LTD claim, EOB 4/6/2014.

NEW SNR: The LTD claim was opened depending on the results of a Peer to Peer review which was ordered by STD DBM but is still not found in STD or LTD claims.

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Review of medicals received include 3/6/14 notes height 6 foot and weight 243 lbs. EE was seen this date for a complete physical.  
Review of exam reveals a well developed male in no acute distress, EE is obese and all the exam findings are normal, including gait, and station, muscle strength/tone are normal. EE to f/u with this provider in 1 year and are far as back pain it 'is persistent and definately disrupting patients life, will refer to SJP for further eval and treatment. Continue PT as it is helping.

Assessment: The medicals reviewed do not support a functional impairment which would prevent working a SEDENTARY occupation.  
There are no recent medicals from the Orthopedic provider and SNR is unsure what the abbreviation of SJP is? EE was to have further work up to his lower back pain?

Plan: Need to obtain the Peer Review and then review with SNR. If needed should deny due to lack of objective medical findings which would prevent working SEDENTARY occupation.

Do you want to generate an LTD Follow up Clinical Review task?

If yes, LTD Follow Up Clinical Review Task Date:

Claim Owner Reassignment	4/24/14	Closed	4/24/14 10:38 am	MARIBEL AMOR	WKAB SYSTEM	WKAB SYSTEM	4/24/14 10:38 am
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Audit information	Claim Owner changed from MARIBEL AMOR to SHAWNDR A LEE
Prior Owner:	MARIBEL AMOR
New Owner:	SHAWNDR A LEE
Claim Status:	Pend
Date of Change:	4/24/2014
Time of Change:	10:38 AM

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Report Date: 10/06/2015

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Claim Tier: Tier 3

Email Response to Member	4/28/14	Closed	4/28/14 1:27 pm	ANASTASIA SNOOK	ANASTASIA SNOOK	ANASTASIA SNOOK	4/28/14 1:27 pm
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To Address List: **REDACTED**

CC Address List:

Do Not Send No

Comments:

Email From Member	4/25/14	Closed	4/28/14 1:28 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	ANASTASIA SNOOK	4/28/14 1:28 pm
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Member Home Email Address **REDACTED**

Date and Time Submitted 4/25/2014 9:50:12 AM

Question Category selected My LTD Claim Details

Question Submitted I see my claims representative has changed, is there any update on my claim?

Plan of Action response to member

Your update has been forwarded to your Claim Manager along with a request to call you. She will call you in the next 24 business hours. Be advised, when someone from Aetna calls you, it may show on your caller ID as blocked, restricted or unknown, so please answer those calls.

Inquiry Analysis: Claim status

Details of Inquiry:

Response Analysis: Customer Service response

Details of Response:

Response Method: Reply via email

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Email From Member	4/29/14	Closed	4/29/14 6:47 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	ANASTASIA SNOOK	4/29/14 6:47 pm
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Member Home Email Address	<b>REDACTED</b>
Date and Time Submitted	4/29/2014 6:16:27 AM
Question Category selected	Other
Question Submitted	The past several days the burning in my feet has gotten much worst. I have suffered the foot burning for quite some time but it was most prevalent at night. Yesterday morning my feet started burning and it kept coming and going in phases all day. Lats night I woke up after an hours sleep feet really burning, took a Tramadol but could not fall back to sleep until 330Am. Up again at 5AM and feet continue to burn. I will call Dr Greens office this morning.
Plan of Action	no response needed
Inquiry Analysis:	Other
Details of Inquiry:	
Response Analysis:	Customer Service response
Details of Response:	
Response Method:	Reply none/duplicate

Email Response to Member	5/5/14	Closed	5/5/14 1:39 pm	ANASTASIA SNOOK	ANASTASIA SNOOK	ANASTASIA SNOOK	5/5/14 1:39 pm
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To Address List:	<b>REDACTED</b>
CC Address List:	
Do Not Send	No

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Report Date: 10/06/2015



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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Comments:

Email From Member	5/5/14	Closed	5/5/14 1:39 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	ANASTASIA SNOOK	5/5/14 1:39 pm
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Member Home Email Address

**REDACTED**

Date and Time Submitted

5/5/2014 1:33:03 PM

Question Category selected

My LTD Claim Details

Question Submitted

Will there be a decision tomorrow as promised?

Plan of Action

response to member

We forwarded your email to your Claim Manager along with a request to call you. She will call you in the next 24 business hours. Be advised, when someone from Aetna calls you, it may show on your caller ID as blocked, restricted or unknown, so please answer those calls.

Inquiry Analysis:

Claim status

Details of Inquiry:

Response Analysis:

Customer Service response

Details of Response:

Response Method:

Reply via email

Clinical Review Acknowledgement	4/22/14	Closed	5/5/14 3:35 pm	SHAWNDR A LEE	TAYLOR SMITH JR	WANDA GREENE-CELESTINE	5/5/14 3:35 pm
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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Recommendations:

STD HISTORY: no previous claims  
 FMLA HISTORY: no previous claims  
 FDA: 10/9/2013  
 EE CURRENTLY APPROVED: 10/9/2013-2/13/2014

EE JOB TITLE/CLASSIFICATION: Inside Sales Acct Mgmt, SEDENTARY occupation  
 - J/D in claim  
 - No push, pull, lift, overhead work  
 EE CO-MORBIDS: Diabetes, HTN, GERD

EE DIAGNOSIS: rotator cuff repair on 10/11/2013 and 1/31/14

MDA GUIDELINES:  
 - 7/10/42  
 - MIN MDA: 10/16/2013  
 - OPT MDA: 10/19/2013  
 - MAX MDA: 11/19/2013  
 - EE currently approved 128 days into STD benefits, outside of mda guidelines for procedure/occ.  
 BHU INVOLVEMENT: none  
 VOCATIONAL REHAB INVOLVEMENT: none  
 IHD CONSENT ON FILE: EE does not have Aetna insurance  
 REVIEW OF MEDICAL SYSTEMS: n/a

REVIEW OF RECENT MEDICALS IN CLAIM:  
 Most recent APS states the following:  
 - EE slow to progress with therapy  
 - LOV 11/15/2013  
 - NOV 12/13/2013  
 - RTW: 1/14/2013  
 - EE to continue PT 2-3 times per week  
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EE had PT/Office visit on 11/15/2013:  
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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
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Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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- rom values affected shoulder: flexion 125 (normal 180), abduction 80 (normal 150), external rotation 40 (normal 40-60), internal rotation 50 (normal 90)
- passive shoulder rom is severely impaired
- EE has improved his rom values since surgery
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- plan: continue PT, follow up with provider one month

EE had OV 12/13/2013:

- continue to c/o discomfort
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- plan: progress to active therapy program and light strength, follow up in one month

EE had right rotator cuff repair on 1/31/2014.

MDA guidelines from 1/31/2014 surgery date:  
 7/10/42  
 min mda: 2/6/2014  
 opt mda: 2/9/2014  
 max mda: 3/13/2014

EE had OV 2/11/2014:

- EE had sutures removed, continue sling
- work on pendulum exercises and passive rom in therapy
- NOV 3/11/2014

EE is not released to rtw for 3 months.

EE has been terminated on 2/7/2014 from Dell.

EE has open LTD claim, EOB 4/6/2014.

NEW SNR: The LTD claim was opened depending on the results of a Peer to Peer review which was ordered by STD DBM but is still not found in STD or LTD claims.

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Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan: Need to obtain the Peer Review and then review with SNR. If needed should deny due to lack of objective medical findings which would prevent working SEDENTARY occupation.

Plan of Action:

.

Clinical Consultant Referral	5/5/14	Closed	5/5/14 3:43 pm	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	5/5/14 3:43 pm
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Level of Referral:	2 - Clinical Review for Claim Determination
Name:	CAROLE BISHOP
Reason for Review:	Pending claim assessment of function and/or work capacity
If Other:	
Claim Type:	LTD Claim
Requestor Name:	SHAWNDR A LEE
Requestor Phone Number:	6932227
Last Day Worked:	10/08/2013

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Disability Date:	10/09/2013
Benefit End Date:	10/31/2028
Benefits Approved Through:	
Transition Date:	04/07/2016
Job Title:	INSIDE SALES ACCOUNT MGMT III
Date of current medical information:	03/25/2014
Date of last contact with employee:	03/18/2014
Primary Diagnosis:	ROTATOR CUFF (CAPSULE) SPRAIN
ICD Code Type	ICD9
ICD Code	840.4
ICD Description	ROTATOR CUFF (CAPSULE) SPRAIN
Effective	
ICD Minimum:	1
ICD Maximum:	14
ICD Optimum:	7
ICD Mean:	90
ICD Code Type	ICD9
ICD Code Type	ICD9
ICD Code Type	ICD9
ICD CODE	840.4
ICD CODE	724.2
ICD CODE	719.7

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
ICD Description				ROTATOR CUFF (CAPSULE) SPRAIN			
ICD Description				LUMBAGO			
ICD Description				DIFFICULTY IN WALKING			
CPT Code				23420			
CPT Code				29822			
CPT Code				29822			
CPT Code				29826			
CPT Code				29827			
CPT Description				RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)			
CPT Description				ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED			
CPT Description				ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED			
CPT Description				ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY			
CPT Description				ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR			
Procedure Date				1/31/2014 12:00:00 AM			
Procedure Date				10/11/2013 12:00:00 AM			
Procedure Date				1/31/2014 12:00:00 AM			
Procedure Date				10/11/2013 12:00:00 AM			
Procedure Date				10/11/2013 12:00:00 AM			
Restrictions and Limitations:							
Mandatory Rehab:				Yes			
Pre-existing Condition:				Unavailable			

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Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Reason Case is being referred:

EE IS A 50YOM INSIDE SALES ACCT.MGMT (SED PDL) WHO HAS BEEN IN LEAVE DUE TO DX OF ROTATOR CUFF (CAPSULE) SPRAIN

PLEASE REVIEW PEER TO PEER TO DETERMINE IF FUNCTIONAL IMPAIRMENT IS SUPPORTED

IMAGE 15004343- DATED:5/5/14

Clinical Consultant Review	5/5/14	Closed	5/6/14 2:42 pm	TAYLOR SMITH JR	WANDA GREENE-CELESTINE	TAYLOR SMITH JR	5/6/14 2:42 pm
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Work Capacity

Partial Work Capacity

Level of Referral from Clinical Consultant Referral Task:

2 - Clinical Review for Claim Determination

Additional Info to Consider:

EE IS A 50YOM INSIDE SALES ACCT.MGMT (SED PDL) WHO HAS BEEN IN LEAVE DUE TO DX OF ROTATOR CUFF (CAPSULE) SPRAIN

PLEASE REVIEW PEER TO PEER TO DETERMINE IF FUNCTIONAL IMPAIRMENT IS SUPPORTED

IMAGE 15004343- DATED:5/5/14

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Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Assessment:

STD HISTORY: no previous claims  
 FMLA HISTORY: no previous claims  
 FDA: 10/9/2013  
 EE CURRENTLY APPROVED: 10/9/2013-4/6/14

EE JOB TITLE/CLASSIFICATION: Inside Sales Acct Mgmt, SEDENTARY occupation  
 - J/D in claim  
 - No push, pull, lift, overhead work  
 EE CO-MORBIDS: Diabetes, HTN, GERD

EE DIAGNOSIS: rotator cuff repair on 10/11/2013 & 1/31/14

MDA GUIDELINES:

- 7/10/42
- MIN MDA: 10/16/2013
- OPT MDA: 10/19/2013
- MAX MDA: 11/19/2013
- EE currently approved 128 days into STD benefits, outside of MDA guidelines for procedure/occ.

BHU INVOLVEMENT: none

VOCATIONAL REHAB INVOLVEMENT: none

REVIEW OF RECENT MEDICALS IN CLAIM:

Most recent APS states the following:

- EE slow to progress with therapy
- LOV 11/15/2013
- NOV 12/13/2013
- RTW: 1/14/2013
- EE to continue PT 2-3 times per week
- EE to have same surgery on opposite shoulder once he is healed from this surgery.

EE had PT/Office visit on 11/15/2013:

- EE having decreased shoulder pain, increase low back pain
- ROM values affected shoulder: flexion 125 (normal 180), abduction 80 (normal 150), external rotation 40 (normal 40-60), internal rotation 50 (normal 90)
- passive shoulder rom is severely impaired

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- EE has improved his rom values since surgery
- decreased lumbar rom on exam
- plan: continue PT, follow up w/ provider one month

EE had OV 12/13/2013:

- continue to c/o discomfort
- EE has been doing passive & assisted exercise with therapy
- shoulder ROM: rom values affected shoulder: flexion 127 (normal 180), abduction 90 (normal 150), external rotation 55 (normal 40-60), internal rotation 57 (normal 90)
- plan: progress to active therapy program and light strength, follow up in one month

EE had right rotator cuff repair on 1/31/2014.

MDA guidelines from 1/31/2014 surgery date:  
 7/10/42  
 min mda: 2/6/2014  
 opt mda: 2/9/2014  
 max mda: 3/13/2014

EE had OV 2/11/2014:

- EE had sutures removed, continue sling
- work on pendulum exersives & passive ROM in therapy
- NOV 3/11/2014

EE is not released to rtw for 3 months.  
 EE has been terminated on 2/7/2014 from Dell.  
 EE has open LTD claim, EOB 4/6/2014.

NEW SNR: The LTD claim was opened depending on the results of a Peer to Peer review which was ordered by STD DBM but is still not found in STD or LTD claims.

Review of medicals received include 3/6/14 notes height 6 foot and weight 243 lbs.  
 EE was seen this date for a complete physical.  
 Review of exam reveals a well developed male in no acute distress, EE is obese and all the exam findings are normal, including gait & station, muscle strength/tone are normal.

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

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EE to f/u with this provider in 1 year & are far as back pain it 'is persistent & definately disrupting patients life, will refer to SJP for further eval & treatment. Continue PT as it is helping.

5/6/14: SNR reviewed CNS notes to find that EE was scheduled to have 'knee surgery' on 4/18/15 but there is no documentation of a knee surgery from any provider.

Peer review dated 4/20/14 notes restrictions would be appropriate of sitting, 30 minutes at a time up to 5 1/2 hours per day w/ opportunity to stand, stretch, and/or shift positions every 15 minutes for 2 minutes at one time.

Stand/walk: 30 minutes at a time up to 5 1/2 hours per day combined.

Lift/carry/push/pull: up to 10 lbs occasionally.

Reach overhead or above desk level: Never

Reach at desk level: Frequently

Use of hands to type, hold, grasp, fasten, grip while seated: Unrestricted.

Peer notes these restrictions are appropriate from 3/21/14-5/31/14.

Assessment: It appears to this reviewer that the restrictions other than the time of 5 1/2 hours per day are all within his job functions. EE is not required to lift, carry, push or pull greater than 10 lbs and is not required to lift overhead.

SNR is concerned regarding the mention of knee surgery on 4/18/14?

No

Peer Review Referral:

No

Voc Rehab Referral:

No

BHU Referral

Recommendations:

Plan: Find out if EE had knee surgery on 4/18/14 and what surgery?

Then may apply MDA Guidelines as the STD EOB was 4/6/14 and if EE had knee surgery on 4/18/14, then he would be eligible for LTDB per MDA Guidelines.

It will depend on what knee surgery was done on 4/18/14.

IHD Effective Date:

Check Medical Systems?

No

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Name:	TAYLOR SMITH JR
Do you want to generate an LTD Follow up Clinical Review task?	Yes

LTD Disability Determination	4/11/14	Closed	5/7/14	1:17 pm	SHAWNDR LEE	CAROLE BISHOP	WANDA GREENE-CELESTINE	5/7/14	1:17 pm
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Disability Date:	10/9/2013 12:00:00 AM
Benefit Begin Date:	4/7/2014 12:00:00 AM
Has claimant eligibility been confirmed?	Yes
Is this a pre-existing condition?	Not Applicable
If Yes, what is the date of last treatment?	
Have you reviewed for potential plan/policy exclusions?	Yes
Have all applicable offsets been applied?	Yes
Has the functionality vs. job requirements been addressed before disability determination?	Yes
Do objective/clinical findings support ongoing disability?	Yes
Is the claimant disabled per plan/policy definition of disability?	Yes
Disability Determination	Approved
Tier:	Tier 3
Partial Earnings:	Not Applicable
Pension:	Not Applicable
Salary Continuation/State Cash/STD:	Not Applicable
Third Party	Not Applicable

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Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

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Workers Comp:

Not Applicable

Other:

Not Applicable

If Other:

Work Capacity

No Current Work Capacity

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
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Rationale for decision:

FDA:10/9/2013  
LTD: 4/7/2014  
EE CO-MORBIDS: Diabetes, HTN, GERD

EE IS A 50YOF INSIDE SALES ACCT MGMT WHO WENT ON LEAVE DUE TO DX OF ROTATOR CUFF REPAIR.

JOB REQUIREMENTS: SEDPDL;Lift/carry/push/pull: up to 10 lbs occasionally

FUNCTIONALITY:Rotator Cuff Repairs on 10/11/2013 & 1/31/14  
\*\*

OV 2/11/2014:  
EE had sutures removed, continue sling  
work on pendulum exercises & passive ROM in therapy  
- NOV 3/11/2014  
\*\*

3/6/14 notes height 6 foot and weight 243 lbs.EE was seen this date for a complete physical.Review of exam reveals a well developed male in no acute distress, EE is obese and all the exam findings are normal, including gait & station, muscle strength/tone are normal.

EE to f/u with this provider in 1 year & are far as back pain it 'is persistent & definately disrupting patients life, will refer to SJP for further eval & treatment. Continue PT as it is helping.  
\*\*

Peer review dated 4/20/14 notes restrictions would be appropriate of sitting, 30 minutes at a time up to 5 1/2 hours per day w/ opportunity to stand, stretch, and/or shift positions every 15 minutes for 2 minutes at one time.  
Stand/walk: 30 minutes at a time up to 5 1/2 hours per day combined.  
Lift/carry/push/pull: up to 10 lbs occasionally.Reach overhead or above desk level: Never  
Reach at desk level: Frequently  
Use of hands to type, hold, grasp, fasten, grip while seated: Unrestricted.

Peer notes these restrictions are appropriate from 3/21/14-5/31/14.  
\*\*

5/7/2014 -DBM confirmed with Dr. Renfro's office, ee had atrophy left knee sx 4/18/14, and

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Plan of Action:

a f/u visit 4/26/2014.

STS approving LTD benefits, due to 4/18/2014 sx ee does not have the functional capacity to perform the core elements of his owc occupation as a Inside Sales Acct Mgmt which requires Lift/carry/push/pull: up to 10 lbs occasionally

\*\*\*\*

require actual sx notes

continue to conduct on-going tpc

Employer Contact Email	5/7/14	Closed	5/7/14 1:43 pm	SHAWNDRRA LEE	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	5/7/14 1:43 pm
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To Address List: US\_leave\_administrator@dell.com; Benefits\_Administrator@dell.com

CC Address List: ungerj@aetna.com

Do Not Send No

Comments:

Financial Worknote	5/8/14	Closed	5/7/14 2:02 pm	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	5/7/14 2:02 pm
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#### Notes

#### LTD Benefit Level Authority Review Task Template

\*\*\*\*\*

EE CONTRIB: 0% - N/A

DLW: 10/8/2013

DCI: 10/9/2013

ANY RTW DURING EP: N/A

LTD BNFT EFF

ANY SUCCESSIVE AFTER EP: N/A

MRBE: \$5,284.34

BNFT: 60%

IMAX: \$3,170.61

ER MAX: N/A

MIN BNFT: \$100 OR 10% WHICHEVER IS GREATER

OIQ ON FILE: ON FILE

RA ON FILE: ON FILE

OFFSET: STATE DISABILITY (NY, NJ, CA, HI, PR, RI)

STATE TAX (NC, VA, IL, OH (work Portsmouth/Columbus)?:

(ATLAS only)

TAX: (ATLAS only)

DEDUCTION: N/A

REMARKS:

TOTAL INITIAL PAYMENT

4/7/2014- 4/30/2014

GROSS/OFFSET/NET BNFT

\$2,536.49/\$00.00/\$2,536.49

5/1/2014- ON-GOING

GROSS/OFFSET/NET BNFT

\$3,170.61/\$00.00/ \$3,170.61

#### Plan of Action

#### Section B

Have you reviewed the claim and agree with the benefit calculation being requested above?

Yes \_\_\_x\_ No \_\_\_

If No is selected, please document reason not approving and recommendations/instructions:

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Regular Approval (LTD)	5/7/14	Closed	5/7/14 2:33 pm	SHAWNDR LEE	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	5/7/14 2:33 pm
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Mailing Method: USPS

Do Not Send No

Comments:

Mail Provider Forms	5/7/14	Closed	5/7/14 2:36 pm	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	5/7/14 2:36 pm
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Mailing Method: USPS

Do Not Send Yes

Comments: Your fax was successfully sent to DR. RENFRO.

Fax number: 6158344722  
 Subject: ARTHUR DAIVS  
 Status: (success)  
 Completed: 2:23:11 PM, Wednesday, May 07, 2014 Sent pages: 2 of 2  
 Duration: 0:00:36  
 Account: GDV GI DIS CLARITY I  
 ID: A210137  
 Received CSID: 16158344722  
 JOBID: 107797852

LTD Determination EE Contact	5/7/14	Closed	5/7/14 2:41 pm	SHAWNDR LEE	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	5/7/14 2:41 pm
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Contact Type: Employee

If other, please specify:

Disability Determination: Approved

Benefits Authorized Thru: 4/6/2016 12:00:00 AM

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Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action:	DBM LEFT VMM REQUESTING RETURN CALL. ONCE CONTACT MADE, DBM WILL ADVISE OF APPROVAL
Contact Outcome:	Left VMM

Clinical Review Acknowledgement	5/6/14	Closed	5/7/14 12:47 pm	SHAWNDRRA LEE	TAYLOR SMITH JR	WANDA GREENE-CELESTINE	5/7/14 12:47 pm
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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Recommendations:

STD HISTORY: no previous claims  
 FMLA HISTORY: no previous claims  
 FDA: 10/9/2013  
 EE CURRENTLY APPROVED: 10/9/2013-4/6/14

EE JOB TITLE/CLASSIFICATION: Inside Sales Acct Mgmt, SEDENTARY occupation  
 - J/D in claim  
 - No push, pull, lift, overhead work  
 EE CO-MORBIDS: Diabetes, HTN, GERD

EE DIAGNOSIS: rotator cuff repair on 10/11/2013 & 1/31/14

MDA GUIDELINES:  
 - 7/10/42  
 - MIN MDA: 10/16/2013  
 - OPT MDA: 10/19/2013  
 - MAX MDA: 11/19/2013  
 - EE currently approved 128 days into STD benefits, outside of MDA guidelines for procedure/occ.  
 BHU INVOLVEMENT: none  
 VOCATIONAL REHAB INVOLVEMENT: none  
 REVIEW OF RECENT MEDICALS IN CLAIM:  
 Most recent APS states the following:  
 - EE slow to progress with therapy  
 - LOV 11/15/2013  
 - NOV 12/13/2013  
 - RTW: 1/14/2013  
 - EE to continue PT 2-3 times per week  
 - EE to have same surgery on opposite shoulder once he is healed from this surgery.

EE had PT/Office visit on 11/15/2013:  
 - EE having decreased shoulder pain, increase low back pain  
 - ROM values affected shoulder: flexion 125 (normal 180), abduction 80 (normal 150), external rotation 40 (normal 40-60), internal rotation 50 (normal 90)  
 - passive shoulder rom is severely impaired

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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- EE has improved his rom values since surgery
- decreased lumbar rom on exam
- plan: continue PT, follow up w/ provider one month

EE had OV 12/13/2013:

- continue to c/o discomfort
- EE has been doing passive & assisted exercise with therapy
- shoulder ROM: rom values affected shoulder: flexion 127 (normal 180), abduction 90 (normal 150), external rotation 55 (normal 40-60), internal rotation 57 (normal 90)
- plan: progress to active therapy program and light strength, follow up in one month

EE had right rotator cuff repair on 1/31/2014.

MDA guidelines from 1/31/2014 surgery date:  
 7/10/42  
 min mda: 2/6/2014  
 opt mda: 2/9/2014  
 max mda: 3/13/2014

EE had OV 2/11/2014:

- EE had sutures removed, continue sling
- work on pendulum exersives & passive ROM in therapy
- NOV 3/11/2014

EE is not released to rtw for 3 months.  
 EE has been terminated on 2/7/2014 from Dell.  
 EE has open LTD claim, EOB 4/6/2014.

NEW SNR: The LTD claim was opened depending on the results of a Peer to Peer review which was ordered by STD DBM but is still not found in STD or LTD claims.

Review of medicals received include 3/6/14 notes height 6 foot and weight 243 lbs.  
 EE was seen this date for a complete physical.  
 Review of exam reveals a well developed male in no acute distress, EE is obese and all the exam findings are normal, including gait & station, muscle strength/tone are normal.

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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<p>Plan of Action:</p>	<p>EE to f/u with this provider in 1 year &amp; are far as back pain it 'is persistent &amp; definately disrupting patients life, will refer to SJP for further eval &amp; treatment. Continue PT as it is helping.</p> <p>5/6/14: SNR reviewed CNS notes to find that EE was scheduled to have 'knee surgery' on 4/18/15 but there is no documentation of a knee surgery from any provider.</p> <p>Peer review dated 4/20/14 notes restrictions would be appropriate of sitting, 30 minutes at a time up to 5 1/2 hours per day w/ opportunity to stand, stretch, and/or shift positions every 15 minutes for 2 minutes at one time. Stand/walk: 30 minutes at a time up to 5 1/2 hours per day combined. Lift/carry/push/pull: up to 10 lbs occasionally. Reach overhead or above desk level: Never Reach at desk level: Frequently Use of hands to type, hold, grasp, fasten, grip while seated: Unrestricted. Peer notes these restrictions are appropriate from 3/21/14-5/31/14.</p> <p>Assessment: It appears to this reviewer that the restrictions other than the time of 5 1/2 hours per day are all within his job functions. EE is not required to lift, carry, push or pull greater than 10 lbs and is not required to lift overhead.</p> <p>SNR is concerned regarding the mention of knee surgery on 4/18/14? dbm spoke with ee and confirmed knee sx, which was performed by dr renfro 4/18/14. ** dbm also spoke with Helen w/ dr. renfro's office who confirmed astrophy left knee sx 4/18/14 *** dbm proceeding with approval of ltd benefits</p>
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Financial Worknote	5/27/14	Closed	5/23/14 3:29 pm	AMANDA FERRANTE	AMANDA FERRANTE	AMANDA FERRANTE	5/23/14 3:29 pm
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<p>Notes</p>	<p>Praxis Disability Group has identified a TPL/Subrogation opportunity and is pursuing same. Please contact Alison Stackpole at 765.216.0240 or alison.stackpole@praxisconsulting.com with any questions.</p>
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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action

Financial Worknote	5/27/14	Closed	5/23/14 3:36 pm	AMANDA FERRANTE	AMANDA FERRANTE	AMANDA FERRANTE	5/23/14 3:36 pm
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Notes

Praxis investigation revealed no viable opportunities for recovery & no TP language in contract. They have closed their file.

Plan of Action

Email Response to Member	5/23/14	Closed	5/23/14 12:40 pm	THEODORA WILLIAMS	THEODORA WILLIAMS	THEODORA WILLIAMS	5/23/14 12:40 pm
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To Address List:

**REDACTED**

CC Address List:

Do Not Send

No

Comments:

Email From Member	5/23/14	Closed	5/23/14 12:41 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB MOBILE	THEODORA WILLIAMS	5/23/14 12:41 pm
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Member Home Email Address

**REDACTED**

Date and Time Submitted

5/23/2014 12:12:39 PM

Question Category selected

My Coverage and Benefits

Question Submitted

I am trying to move and they would like a letter stating I will receive benefits beyond 2 yrs if I do not recover. Is this possible?

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action

email response to member

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

We are able to provide you an income verification letter. We have forwarded a request to your Claim Manager to send the letter to you.

Please let us know if we can provide additional assistance.

Claim management process

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Customer Service response

Details of Response:

Response Method:

Reply via email

Email Response to Member	5/28/14	Closed	5/28/14 12:15 pm	SHERRI MCINNES	SHERRI MCINNES	SHERRI MCINNES	5/28/14 12:15 pm
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To Address List:

**REDACTED**

CC Address List:

Do Not Send

No

Comments:

Email From Member	5/27/14	Closed	5/28/14 12:16 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	SHERRI MCINNES	5/28/14 12:16 pm
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Member Home Email Address

**REDACTED**

Date and Time Submitted

5/27/2014 2:38:31 PM

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Question Category selected

My Claim

Question Submitted

I would like the email address and contact phone number for my case manager please. I went to my Primary Care physician Dr. Tad Yoneyama at Heritage Medical Clinic. He believes I have a pinched nerve which is causing the painful burning of my feet. He was disappointed in the aloof attitude of Dr. Breanna Green not setting an urgency for the EMG. He is afraid the damage will continue and possible lead to numbness and muscle loss. I have scheduled an appointment with his referral Dr Subir Prasab of Heritage Medical Associates Thursday May 29th at 2:40PM

Plan of Action

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Inquiry Analysis:

Claim status

Details of Inquiry:

Response Analysis:

Referred to claim owner

Details of Response:

Response Method:

Reply via email

Email Response to Member	5/30/14	Closed	5/30/14	8:35 pm	GLADYS WALTERS	GLADYS WALTERS	GLADYS WALTERS	5/30/14	8:35 pm
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To Address List:

**REDACTED**

CC Address List:

Do Not Send

No

Comments:

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Email From Member	5/30/14	Closed	5/30/14 8:36 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	GLADYS WALTERS	5/30/14 8:36 pm
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Member Home Email Address	<b>REDACTED</b>
Date and Time Submitted	5/30/2014 12:13:21 PM
Question Category selected	Other
Question Submitted	Good morning I sent two request and have not received a response from either. I would like to email updates directly to my case manager.I do need an income letter.
Plan of Action	Dear MR. ARTHUR DAVIS,  Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.  Your request has been forwarded to your Claim Manager.  Please let us know if we can provide additional assistance. Claim status
Inquiry Analysis:	
Details of Inquiry:	
Response Analysis:	Customer Service response
Details of Response:	
Response Method:	Reply via email

Initial SSDI Review Task	5/7/14	Closed	6/2/14 2:54 pm	SHAWNDR A LEE	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	6/2/14 2:54 pm
Plan Name	DD						

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Work Status	Not At Work
Status	Approved
Reason	Disability Supported
App Start Date	4/7/2014 12:00:00 AM
App Thru Date	4/6/2016 12:00:00 AM
Claim Owner	SHAWNDR A LEE
Claimant Preferred Address:	Home Address
City:	MURFREESBORO
State:	Tennessee
Zip:	37128
Primary Diagnosis	ICD9 : 840.4 - ROTATOR CUFF (CAPSULE) SPRAIN
Disability Date	10/9/2013 12:00:00 AM
Management End Date	
Social Security Type	Disability
Social Security Type	Disability
Level	New Claim
Level	Monitoring
Status	Pending
Status	Pending
Status Date	1/1/0001 12:00:00 AM
Status Date	5/13/2014 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Entitlement Date	1/1/0001 12:00:00 AM
Individual Amount	0
Individual Amount	0
Add'l Earnings Amount	0
Add'l Earnings Amount	0
Dependent Amount	0
Dependent Amount	0
Notes	5/13/14--Allsup reviewed. Allsup not accepting for SSDI representation at this time. Further review required. CAS
Plan of Action	SSC will review claim file again in 60 days.

Free Form Letter STD-LTD	6/2/14	Closed	6/2/14 3:15 pm	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	6/2/14 3:15 pm
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Mailing Method: USPS

Do Not Send No

Comments:

Free Form Letter STD-LTD	6/2/14	Closed	6/2/14 3:21 pm	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	6/2/14 3:21 pm
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Mailing Method: USPS

Do Not Send No

Comments:

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
Correspondence - Incoming	6/12/14	Closed	6/16/14 2:43 pm	SHAWNDR A LEE	WEB SERVICE	WANDA GREENE-CELESTINE	6/16/14 2:43 pm

Image Description: list of providers

Image Notes:

Mail Provider Forms	6/16/14	Closed	6/16/14 2:47 pm	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	6/16/14 2:47 pm
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Mailing Method: USPS

Do Not Send: Yes

Comments: Your fax was successfully sent to Dr. Green.

Fax number: 6158677974  
 Subject: Arthur Davis  
 Status: (success)  
 Completed: 2:43:59 PM, Monday, June 16, 2014 Sent pages: 2 of 2  
 Duration: 0:01:06  
 Account: GDV GI DIS CLARITY I  
 ID: A210137  
 Received CSID: 16158677974  
 JOBID: 110818708

Mail Provider Forms	6/16/14	Closed	6/16/14 3:09 pm	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	6/16/14 3:09 pm
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Mailing Method: USPS

Do Not Send: Yes

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Comments:

Your fax was successfully sent to Yoneyama Heritage Medical.

Fax number: 6159163903  
 Subject: Arthur Davis  
 Status: (success)  
 Completed: 2:59:30 PM, Monday, June 16, 2014 Sent pages: 6 of 6  
 Duration: 0:03:05  
 Account: GDV GI DIS CLARITY I  
 ID: A210137  
 Received CSID: 16159163903  
 JOBID: 110822304

Mail Provider Forms	6/16/14	Closed	6/16/14 3:29 pm	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	6/16/14 3:29 pm
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Mailing Method:

USPS

Do Not Send

Yes

Comments:

Your fax was successfully sent to Premier Orthopaedics & Sports.

Fax number: 6158344722  
 Subject: Arthur Davis  
 Status: (success)  
 Completed: 3:09:54 PM, Monday, June 16, 2014 Sent pages: 6 of 6  
 Duration: 0:01:44  
 Account: GDV GI DIS CLARITY I  
 ID: A210137  
 Received CSID: 16158344722  
 JOBID: 110824391

Mail Provider Forms	6/16/14	Closed	6/16/14 3:31 pm	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	6/16/14 3:31 pm
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Mailing Method:

USPS

Do Not Send

Yes

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Comments:

Your fax was successfully sent to Dr. Prasad.

Fax number: 6159163953  
Subject: Arthur Davis  
Status: (success)  
Completed: 3:18:16 PM, Monday, June 16, 2014 Sent pages: 6 of 6  
Duration: 0:01:35  
Account: GDV GI DIS CLARITY I  
ID: A210137  
Received CSID: 16159163953  
JOBID: 110824959

Mail Provider Forms	6/16/14	Closed	6/16/14 3:38 pm	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	6/16/14 3:38 pm
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Mailing Method:

USPS

Do Not Send

Yes

Comments:

Your fax was successfully sent to DR. KNOX.

Fax number: 6152208688  
Subject: ARTHUR DAVIS  
Status: (success)  
Completed: 3:23:38 PM, Monday, June 16, 2014 Sent pages: 6 of 6  
Duration: 0:02:36  
Account: GDV GI DIS CLARITY I  
ID: A210137  
Received CSID: 6154593869  
JOBID: 110826548

Analysis/Review Medical Records	5/7/14	Closed	6/16/14 3:39 pm	SHAWNDR A LEE	SANTOSH KUMAR	WANDA GREENE-CELESTINE	6/16/14 3:39 pm
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Image Description

Analysis/Review Medical Records

Image Notes

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Date Medical Received	05/07/2014
Type of Information Recd-select all that apply	Office/Progress Notes
If Other Information Received, please describe:	
Provider Name:	
Diagnosis:	
If Other, please specify:	
CPT Search:	
CPT Code	23420
CPT4 Description	RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)
Procedure Date:	1/31/2014
Date of Disability:	10/9/2013
RTW Date (if provided):	
Notes	PROGRESS NOTES
Plan of Action	N/A
CPT Code	29822
CPT Code	29822
CPT Code	29826
CPT Code	29827
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

Faxed Form Request	6/20/14	Closed	6/20/14 11:44 am	MARTHA WILEY	MARTHA WILEY	MARTHA WILEY	6/20/14 11:44 am
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Mailing Method: USPS

Comments:

Fax Form Confirmation Task	6/20/14	Closed	6/20/14 11:59 am	MARTHA WILEY	MARTHA WILEY	MARTHA WILEY	6/20/14 11:59 am
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Please enter the internal work note.

Your fax was successfully sent to To Dr Subir Prasad.

Fax number: 6159163953  
 Subject: Attending Physician Statement/Capabilities and Limitations Worksheet  
 Status: (success)  
 Completed: 11:50:17 AM, Friday, June 20, 2014 Sent pages: 8 of 8  
 Duration: 0:01:54  
 Account: ASO MAPS DIS OR CSR  
 ID: A805974  
 Received CSID: 16159163953  
 JOBID: 111237256

Faxed Form Request	6/23/14	Closed	6/23/14 10:53 am	JACOB PETERSON	JACOB PETERSON	JACOB PETERSON	6/23/14 10:53 am
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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Mailing Method: USPS

Comments:

Fax Form Confirmation Task	6/23/14	Closed	6/23/14 12:32 pm	JACOB PETERSON	JACOB PETERSON	JACOB PETERSON	6/23/14 12:32 pm
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Please enter the internal work note. Your fax was successfully sent to Dr. SUBIR PRASAD.

Fax number: 615-916-3953  
 Subject:  
 Status: (success)  
 Completed: 10:55:30 AM, Monday, June 23, 2014 Sent pages: 7 of 7  
 Duration: 0:02:11  
 Account: ASO SO LRB DI TAMPA CSR  
 ID: A595234  
 Received CSID: 16159163953  
 JOBID: 111334084

Analysis/Review Medical Records	6/18/14	Closed	7/9/14 9:19 am	SHAWNDR A LEE	ANIL KUMAR	EVELYNE MILLER	7/9/14 9:22 am
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Image Description	Doctor's note
Image Notes	
Date Medical Received	06/18/2014
Type of Information Recd-select all that apply	200002 200005
If Other Information Received, please describe:	Procedure notes
Provider Name:	Dr. Brenda Greene
Diagnosis:	Rotator cuff
If Other, please specify:	

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Report Date: 10/06/2015



Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT Search:

CPT Code 23420

CPT4 Description RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)

Procedure Date: 1/31/2014

Date of Disability: 10/9/2013

RTW Date (if provided):

Notes DBM received office notes from Dr. Greene dated 5/06/14 and Procedure notes dated 4/14/14

Plan of Action DBM will contact EE for initial TPC  
DBM will forward medicals for review  
DBM will update initial assessment

CPT Code 29822

CPT Code 29822

CPT Code 29826

CPT Code 29827

CPT4 Description ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

CPT4 Description ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

CPT4 Description ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY

CPT4 Description ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR

Procedure Date: 10/11/2013

Procedure Date: 1/31/2014

Procedure Date: 10/11/2013

Procedure Date: 10/11/2013

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Analysis/Review Medical Records	6/26/14	Closed	7/9/14 9:51 am	SHAWNDR A LEE	WEB SERVICE	EVELYNE MILLER	7/9/14 9:51 am
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Image Description	APS received from Dr. Subir Prasad C & L worsheet
Image Notes	
Date Medical Received	06/26/2014
Type of Information Recd-select all that apply	200001 200005
If Other Information Received, please describe:	C & L worsheet
Provider Name:	Dr. Subir Prasad
Diagnosis:	Other
If Other, please specify:	Paresthesia
CPT Search:	
CPT Code	23420
CPT4 Description	RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)
Procedure Date:	1/31/2014
Date of Disability:	10/9/2013
RTW Date (if provided):	
Notes	DBM received APS from Dr. Prasad dated 06/25/14 for Dx: Paresthesia 782.0 C & L worsheet received 6/25/14 Last treatment 5/29/14.
Plan of Action	DBM will contact EE for initial TPC DBM will forward medical records for review DBM will update initial assessment
CPT Code	29822

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT Code	29822
CPT Code	29826
CPT Code	29827
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

Analysis/Review Medical Records	6/19/14	Closed	7/9/14 10:44 am	SHAWNDR A LEE	SANJEEV KUMAR	SHAWNDR A LEE	7/9/14 10:44 am
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Image Description	EE note
Image Notes	
Date Medical Received	06/19/2014
Type of Information Recd-select all that apply	Other
If Other Information Received, please describe:	Note from EE
Provider Name:	Note from EE
Diagnosis:	Other
If Other, please specify:	ROTATOR CUFF (CAPSULE) SPRAIN
CPT Search:	

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT Code	23420
CPT4 Description	RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)
Procedure Date:	1/31/2014
Date of Disability:	10/9/2013
RTW Date (if provided):	
Notes	EE submitted noted advising of most recent OV.
Plan of Action	DBM will request medicals from Providers for updated medicals
	DBM will make outreach to EE for ongoing TPC.
	DBM will forward medicals to SNR for review once received.
CPT Code	29822
CPT Code	29822
CPT Code	29826
CPT Code	29827
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Analysis/Review Medical Records	6/20/14	Closed	7/9/14 10:45 am	SHAWNDR LEE	ASHUTOSH NARAYAN SINGH	SHAWNDR LEE	7/9/14 10:45 am
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Image Description	APS received from Dr.Tad Yoneyama 06/20/2014.
Image Notes	
Date Medical Received	06/20/2014
Type of Information Recd-select all that apply	200001 200005
If Other Information Received, please describe:	medication list
Provider Name:	Dr. Tad Yoneyama
Diagnosis:	Other
If Other, please specify:	Paresthesia, Shoulder pain
CPT Search:	
CPT Code	23420
CPT4 Description	RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)
Procedure Date:	1/31/2014
Date of Disability:	10/9/2013
RTW Date (if provided):	
Notes	DBM received APS from Dr. Tad Yoneyama dated 6/20/14 EE dx: Shoulder pain 719.41 Paresthesia Symptoms:shoulder pain, back pain, knee pain, foot pain Per APS: No lifting, no pulling, no pushing, no prolonged sitting EE last surgery 4/23/14 Treatment: medication management & referral to Neuro/Ortho

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action	DBM will contact EE for initial TPC DBM will forward medical records for review DBM will update initial assessment
CPT Code	29822
CPT Code	29822
CPT Code	29826
CPT Code	29827
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

Correspondence - Incoming	6/20/14	Closed	7/9/14 10:48 am	SHAWNDR LEE	ASHUTOSH NARAYAN SINGH	SHAWNDR LEE	7/9/14 10:48 am
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Image Description:	CLW
Image Notes:	Incomplete C&L worksheet

Correspondence - Incoming	6/26/14	Closed	7/9/14 10:50 am	SHAWNDR LEE	PAWAN KUMAR	SHAWNDR LEE	7/9/14 10:50 am
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Image Description:	Correspondence - Incoming
Image Notes:	coversheet

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Correspondence - Incoming	7/9/14	Closed	7/11/14 11:58 am	SHAWNDR LEE	SAURABH GUPTA	SHAWNDR LEE	7/11/14 11:58 am
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Image Description: FAX

Image Notes: Request for meds

Correspondence - Incoming	7/10/14	Closed	7/11/14 11:59 am	SHAWNDR LEE	ANKESH KUMAR	SHAWNDR LEE	7/11/14 11:59 am
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Image Description: Correspondence - Incoming

Image Notes: Request for Auth

Analysis/Review Medical Records	7/10/14	Closed	7/11/14 12:02 pm	SHAWNDR LEE	ASHUTOSH NARAYAN SINGH	SHAWNDR LEE	7/11/14 12:02 pm
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Image Description: MED NOTES

Image Notes:

Date Medical Received: 07/10/2014

Type of Information Recd-select all that apply: Office/Progress Notes

If Other Information Received, please describe:

Provider Name: Dr. Knox

Diagnosis: Rotator cuff

If Other, please specify:

CPT Search:

CPT Code: 23420

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT4 Description	RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)
Procedure Date:	1/31/2014
Date of Disability:	10/9/2013
RTW Date (if provided):	
Notes	<p>DBM received OVN from Dr. Knox dated 06/09/2014</p> <p>EE is to f/u with back specialist regarding restrictions.</p> <p>EE does nto have f/u visit with Dr. Knox at this time.</p> <p>DBM will forward medicals to SNR for review</p>
Plan of Action	<p>DBM will f/u with EE for update TPC</p>
CPT Code	29822
CPT Code	29822
CPT Code	29826
CPT Code	29827
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

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Report Date: 10/06/2015



Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Email Response to Member	7/14/14	Closed	7/14/14 3:47 pm	THEODORA WILLIAMS	THEODORA WILLIAMS	THEODORA WILLIAMS	7/14/14 3:47 pm
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To Address List: **REDACTED**

CC Address List:

Do Not Send No

Comments:

Email From Member	7/14/14	Closed	7/14/14 3:48 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB MOBILE	THEODORA WILLIAMS	7/14/14 3:48 pm
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Member Home Email Address **REDACTED**

Date and Time Submitted 7/14/2014 11:01:14 AM

Question Category selected My Claim

Question Submitted Good morning I am following up to make sure my case manager received my Treating Physician statement. Are there any poem items on my part?

Plan of Action email response to member

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

We received your medical information for review on 07/10/2014. Your Claim Manager will notify you if any additional information is needed.

Please let us know if we can provide additional assistance.

Was Paperwork received

Inquiry Analysis:

Details of Inquiry:

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Response Analysis: Customer Service response

Details of Response:

Response Method: Reply via email

Email Response to Member	7/15/14	Closed	7/15/14 1:56 pm	ANASTASIA SNOOK	ANASTASIA SNOOK	ANASTASIA SNOOK	7/15/14 1:56 pm
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To Address List: **REDACTED**

CC Address List:

Do Not Send No

Comments:

Email From Member	7/15/14	Closed	7/15/14 1:57 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	ANASTASIA SNOOK	7/15/14 1:57 pm
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Member Home Email Address **REDACTED**

Date and Time Submitted 7/15/2014 12:21:18 PM

Question Category selected My Claim

Question Submitted I had an appointment with Dr. Tad Yoneyama at Heritage Medical Group, Franklin, TN  
He suggested I try Cymbalta again. Eat before taking the medicine and try to work through  
initial side effects. Started last night and I will pickup script this morning.

Plan of Action response to member

We forwarded your email to your Claim Manager to update her. She will contact you with any  
questions.

Inquiry Analysis: Claim status

Details of Inquiry:

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Response Analysis:	Customer Service response
Details of Response:	
Response Method:	Reply via email

Analysis/Review Medical Records	7/9/14	Closed	7/16/14 9:11 am	SHAWNDR A LEE	YADAV VIKAS	BIBI ALLI	7/16/14 9:11 am
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Image Description	med
Image Notes	
Date Medical Received	07/09/2014
Type of Information Recd-select all that apply	Office/Progress Notes
If Other Information Received, please describe:	
Provider Name:	Breena Green
Diagnosis:	Rotator cuff
If Other, please specify:	
CPT Search:	
CPT Code	23420
CPT4 Description	RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)
Procedure Date:	1/31/2014
Date of Disability:	10/9/2013
RTW Date (if provided):	
Notes	Blank request form from Dr Green

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action	DBM need to obtain updated medical records, diagnostic test result (s), review records with CC and obtain RTW status from treating provider.						
CPT Code	29822						
CPT Code	29822						
CPT Code	29826						
CPT Code	29827						
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED						
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED						
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY						
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR						
Procedure Date:	10/11/2013						
Procedure Date:	1/31/2014						
Procedure Date:	10/11/2013						
Procedure Date:	10/11/2013						

Analysis/Review Medical Records	7/9/14	Closed	7/16/14	9:18 am	SHAWNDR A LEE	VINIT SHARMA	BIBI ALLI	7/16/14	9:18 am
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Image Description	Analysis/Review Medical Records
Image Notes	Dup of Image #15435473
Date Medical Received	07/09/2014
Type of Information Recd-select all that apply	Office/Progress Notes
If Other Information Received, please describe:	
Provider Name:	Breena Green

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Diagnosis:

If Other, please specify:

CPT Search:

CPT Code

23420

CPT4 Description

RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)

Procedure Date:

1/31/2014

Date of Disability:

10/9/2013

RTW Date (if provided):

Notes

Blank request form from Dr Green.  
Duplicate of Image #: 15435473

Plan of Action

DUP

CPT Code

29822

CPT Code

29822

CPT Code

29826

CPT Code

29827

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR

Procedure Date:

10/11/2013

Procedure Date:

1/31/2014

Procedure Date:

10/11/2013

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Procedure Date: 10/11/2013

Analysis/Review Medical Records	7/10/14	Closed	7/16/14 9:26 am	SHAWNDR LEE	PAWAN KUMAR	BIBI ALLI	7/16/14 9:26 am
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Image Description	RTW
Image Notes	RTW analysis form from Dr Breena Green
Date Medical Received	07/09/2014
Type of Information Recd-select all that apply	Office/Progress Notes
If Other Information Received, please describe:	
Provider Name:	Breena Green
Diagnosis:	
If Other, please specify:	
CPT Search:	
CPT Code	23420
CPT4 Description	RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)
Procedure Date:	1/31/2014
Date of Disability:	10/9/2013
RTW Date (if provided):	

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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#### Notes

Completed RTW analysis form received from Dr Green 07/09/2014.

Current treatment plan: HEP, weight management, pain medication.

LOV: 06/19/2014

NOV: 07/31/2014

RTW Plan: He need a functional capacity evaluation to evaluate his abilities/restrictions.

Anticipated Full Duty RTW: TBD.

Signed and dated 07/09/2014

#### Plan of Action

DBM to follow up with Dr. Green for NOV notes, RTW status, obtain any updated diagnostic test result(s) and follow up with EE.

CPT Code

29822

CPT Code

29822

CPT Code

29826

CPT Code

29827

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY

CPT4 Description

ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR

Procedure Date:

10/11/2013

Procedure Date:

1/31/2014

Procedure Date:

10/11/2013

Procedure Date:

10/11/2013

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Follow Up SSDI Review Task	7/21/14	Closed	7/21/14 8:18 am	SHARON RAND	SHARON RAND	SHARON RAND	7/21/14 8:18 am
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Social Security Type	Disability
Social Security Type	Disability
Level	New Claim
Level	Monitoring
Status	Pending
Status	Pending
Status Date	1/1/0001 12:00:00 AM
Status Date	5/13/2014 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Individual Amount	0
Individual Amount	0
Add'l Earnings Amount	0
Add'l Earnings Amount	0
Dependent Amount	0
Dependent Amount	0
Notes:	Allsup Review: Allsup deferred representation at this time. Allsup will follow up in two months for claim review.
Plan of Action:	see above.

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Email Response to Member	8/4/14	Closed	8/2/14 6:36 pm	SHERRI MCINNES	SHERRI MCINNES	SHERRI MCINNES	8/2/14 6:36 pm
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To Address List: **REDACTED**

CC Address List:

Do Not Send No

Comments:

Email From Member	8/1/14	Closed	8/2/14 6:36 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	SHERRI MCINNES	8/4/14 12:48 pm
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Member Home Email Address **REDACTED**

Date and Time Submitted 8/1/2014 6:19:51 PM

Question Category selected Other

Question Submitted

I tried to see my Pain Management doctor on Thursday July 31st and unfortunately I was 7 minutes late and she refused to see me. I have requested that my primary care doctor Tad Yoneyama, M.D. - Heritage Medical Associates provide my pain management treatment of Tramadol and Cymbalta versus Dr. Breanna Green. Dr Green has informed me previously that she cannot offer any other solution but pain medication and she charges twice as much for her consultations and I do not have the same personal relationship I have with my primary doctor. I feel he can offer better solutions.

Plan of Action

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Claim status

Inquiry Analysis:

Details of Inquiry:

Response Analysis: Referred to claim owner

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Details of Response:

Response Method: Reply via email

Correspondence - Incoming	7/21/14	Closed	8/4/14 12:56 pm	SHAWNDR A LEE	PAVAN KUMAR	WANDA GREENE-CELESTINE	8/4/14 12:56 pm
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Image Description: open subragation case with rawlings grp. contact person:Adam Wilson,800-928-1279 ext2305

Image Notes:

LTD Claimant Interview	7/3/14	Closed	8/15/14 1:01 pm	SHAWNDR A LEE	MARIBEL AMOR	WANDA GREENE-CELESTINE	8/15/14 1:01 pm
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Completed Contact Type: Employee

If Attorney or "Other"

Please define:

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Report Date: 10/06/2015

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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#### Notes

#### Current Treatment:

What is your current treatment plan?  
 medication  
 recreation center: physical therapy exercises  
 daily basis. cant afford to continue to pay for pt  
 physical therapy: last treatment may 2014

How do you think your recovery is progressing?  
 not prgressing well. severe back pain

What physicians are currently treating you?  
 Dr. Yoneyama

When was your last office visit with your physician(s)? July 2014

When is/are your next visit(s) scheduled?

What are your current medications and dosages? (If any)  
 tramadol - 50mg twice per day  
 cymbalta -30mg once per day  
 over the counter - arthritis tylenol

How has your condition impacted your daily activities? (Housework, driving, child or elder care issues): not able to go many palces. drives son to school, takes a nap.  
 if he has to shop his son or ex wife goes with him to lift bags.

Who lives with you? moved in with ex wife to help with his expensives

What are your thoughts on returning to work? not able to return to work

Have you discussed this with your AP? have not had a discssion

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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What contacts have you made with your employer since your disability.no

Would you like any assistance in order to return to work? (Rehab program Note: Some contracts have mandatory rehab):

OFF SETS: SSDI / WC / PENSION (Explain the ALLSUP process if applicable): had pycssch exam with ssa

What is the status of your Social Security Disability claim? pending

What are the dates of birth of your dependent children? **REDACTED**

Are you eligible for a pension / retirement benefit from work? If so, are you currently receiving any benefits? no

Are you receiving any benefits from Workers Comp? If so, ask for details including if a settlement is pending. no

Assistive devices: not using any at this time.  
n/a

continue to conduct on-going tpc.

Early Any Occupation Assessment  
Plan of Action

Mail Provider Forms	8/15/14	Closed	8/15/14 2:22 pm	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	WANDA GREENE-CELESTINE	8/15/14 2:22 pm
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Mailing Method: USPS

Do Not Send Yes

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Comments:

Your fax was successfully sent to Dr. Yoneyama.

Fax number: 6159163903  
 Subject: Arthur Davis  
 Status: (success)  
 Completed: 2:21:06 PM, Friday, August 15, 2014 Sent pages: 6 of 6  
 Duration: 0:01:35  
 Account: GDV GI DIS CLARITY I  
 ID: A210137  
 Received CSID: 16159163903  
 JOBID: 115829907

Email Response to Member	8/18/14	Closed	8/16/14 12:47 pm	SHERRI MCINNES	SHERRI MCINNES	SHERRI MCINNES	8/18/14 1:24 pm
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To Address List:

**REDACTED**

CC Address List:

Do Not Send

No

Comments:

Email From Member	8/15/14	Closed	8/16/14 12:48 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	SHERRI MCINNES	8/16/14 12:48 pm
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Member Home Email Address

**REDACTED**

Date and Time Submitted

8/15/2014 6:10:59 PM

Question Category selected

My Provider

Question Submitted

My next appointment is with Dr. Tad Yoneyama of Heritage Medical Clinic Jan 14th 2015.  
 Current treatment is pain medication. I would be willing to go to any back specialist recommended by Aetna to help with the back pain.

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Claim status

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Customer Service response

Details of Response:

Response Method:

Reply via email

Email Response to Member	9/11/14	Closed	9/11/14 12:09 pm	ANASTASIA SNOOK	ANASTASIA SNOOK	ANASTASIA SNOOK	9/11/14 12:09 pm
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To Address List:

**REDACTED**

CC Address List:

Do Not Send

No

Comments:

Email From Member	9/11/14	Closed	9/11/14 12:09 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	ANASTASIA SNOOK	9/11/14 12:09 pm
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Member Home Email Address

**REDACTED**

Date and Time Submitted

9/11/2014 7:30:55 AM

Question Category selected

My Claim

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Question Submitted	Good morning I have started Spinal Decompression treatment with Dr Derek Totty at Totty Chiropractic of Mt Juliet. 541 N Mt Juliet Rd, Mt Juliet TN 37122 615-758-7101. The session is supposed to run 20 treatments. I am open to any suggestions for pain relief.
Plan of Action	response to member  Your update has been forwarded to your Claim Manager. She will contact Dr Totty to collect medical information if needed.
Inquiry Analysis:	Claim status
Details of Inquiry:	
Response Analysis:	Customer Service response
Details of Response:	
Response Method:	Reply via email

Correspondence - Incoming	8/18/14	Closed	9/15/14 1:13 pm	SHAWNDR A LEE	KAPIL SINGH	WANDA GREENE-CELESTINE	9/15/14 1:13 pm
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Image Description: incomplete CLW

Image Notes:

Email From Member	9/15/14	Closed	9/15/14 1:16 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	WANDA GREENE-CELESTINE	9/15/14 1:16 pm
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Member Home Email Address **REDACTED**

Date and Time Submitted 9/15/2014 1:00:54 PM

Question Category selected My Coverage and Benefits

Question Submitted Good morning I am having difficulty with depression and handling my current situation. I asking for a referral for psychiatrist.

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action	contact ee regarding request
Inquiry Analysis:	Other
Details of Inquiry:	
Response Analysis:	Referred to management
Details of Response:	STS contacted ee regarding his request
Response Method:	Reply via return call

Analysis/Review Medical Records	8/18/14	Closed	9/18/14 11:11 am	SHAWNDR LEE	KAPIL SINGH	BIBI ALLI	9/18/14 11:11 am
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Image Description	APS
Image Notes	
Date Medical Received	08/18/2014
Type of Information Recd-select all that apply	200001 200002
If Other Information Received, please describe:	
Provider Name:	Dr. Yoneyama, MD
Diagnosis:	
If Other, please specify:	
CPT Search:	
CPT Code	23420
CPT4 Description	RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)
Procedure Date:	1/31/2014
Date of Disability:	10/9/2013

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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RTW Date (if provided):

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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## Notes

OV Notes for DOS 07/14/2014

### History of Present Illness

The patient is a 50 year old male who presents for a follow up of chronic conditions. 6 mth, needs refill on spiro lactone, wt up 4lbs.  
 did not get condo b/c did not qualify  
 ex-wife renting house, she offered room at her place \$500/month she is working 2 jobs  
 son working at McDonalds  
 LBP radiates down leg 6-8/10 burning with intermittent bee sting pain  
 pain doc - cymbalta caused tingling in legs neck and LBP, not relieved with aleve  
 neuro- pamelor helped but bladder side effects could not go  
 exercise walk treadmill 1 hr daily  
 takes tylenol and 1/2 tab tramadol 30mm before treadmill  
 diet not good  
 1 month ago 260lbs -> 246lbs today  
 some mood swings  
 no chest pain/SOB/DOE/dizziness/nausea/GERD  
 fall going to online MTSU computer

### Medication:

Omeprazole 20mg  
 Celebrex 200mg  
 Zyrtec Allergy 10mg  
 Bystolic 10mg  
 Flonase 50mg  
 Advair Diskus 250-50mcg  
 Lisinopril-Hydrochlorothiazide 20-25mg  
 EpiPen 2-Pak 0.3mg  
 Lotrisone 1-0.05%  
 Clonidine HCl 0.1mg  
 Amlodipine Besylate 10mg  
 Diazepam 5mg  
 Dulera 200-5mcg  
 Spironolactone 25mg

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Review of Systems  
 General; Not Present- Chills, Fatigue, Feeling Sick, Fever and Night Sweats.  
 Skin: Not Present- Dryness, Itching, Nail Changes, New Lesions and Rash.  
 HEENT: Present- Headache and Wears glasses/contact lenses, Not Present- Visual Disturbances, Hearing Loss, Ear Pain, Ringing in the Ears, Vertigo, Runny Nose, Nasal Congestion, Seasonal Allergies and Sore Throat.  
 Neck: Not Present- Neck Pain, Neck Stiffness and Swollen Glands.  
 Respiratory; Present- Shortness of Breath. Not Present- Cough and Wheezing.  
 Cardiovascular: Present- Abnormal Blood Pressure. Not Present- Chest Pain, Edema, Leg Cramps and Palpitations.  
 Gastrointestinal: Present- Heartburn and Nausea, Not Present- Abdominal Pain, Change in Bowel Habits,  
 Constipation, Diarrhea, Dysphagia, Jaundice, Rectal Bleeding and Vomiting.  
 Male Genitourinary: Not Present- Difficulty with Erection, Dysuria, Hematuria, Nocturia and Polyuria.  
 Musculoskeletal: Present- Back Pain and Joint Pain. Not Present- Decreased Range of Motion, Muscle Cramps, Muscle Weakness and Myalgia.  
 Neurological: Present- Headaches, Numbness and Paresthesias, Not Present- Dizziness, Focal Neurological Symptoms, Seizures and Syncope.  
 Psychiatric: Present- Mood changes (HIGH stress level). Not Present- Anxiety, Depression, Insomnia, Memory Loss, Panic Attacks and Trouble Falling Asleep.  
 Endocrine: Not Present- Appetite Changes and Libido Change.  
 Hematology: Not Present- Abnormal Bleeding, Easy Bruising and Painful Lymph Nodes.  
 Vitals  
 07/14/2014 10:25 AM  
 Weight: 246 lb Height: 72 in, BP: 144/100  
 Body Surface Area; 2.38 m2 Body Mass Index: 33.36 kg/m2

Assessment & Plan  
 Paresthesia (782.0 I R20.2)  
 Problem Story burning all day and night, feet and lower shin off/on; worse when legs straight or sit for long time, sched for EMG 6/13/2014 Dr William Newton at M&boro Med Clinic, LBP,

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Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action	paresthesia worsening, no weakness/numbness, Lyrica-> after 3 days, tingle in hands/feet Neurontin - felt stupid, still on tramadol at night Today's Impression: likely due to radicular pain, refer to neuro Degenerative lumbar disc (72232 f 1451.36) Today's Impression: presume mild by history; again doubt source of foot pain DBM to review claim
CPT Code	29822
CPT Code	29822
CPT Code	29826
CPT Code	29827
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

Email Response to Member	9/19/14	Closed	9/19/14 8:26 am	SUSAN STEWART	SUSAN STEWART	SUSAN STEWART	9/19/14 8:26 am
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To Address List: **REDACTED**

CC Address List:

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Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Do Not Send

No

Comments:

Email From Member	9/18/14	Closed	9/19/14 8:27 am	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	SUSAN STEWART	9/19/14 8:27 am
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Member Home Email Address

**REDACTED**

Date and Time Submitted

9/18/2014 6:29:20 PM

Question Category selected

My Claim

Question Submitted

Good afternoon I found the chiropractic treatments to be more harmful then good. My feet seemed to burn more, especially at night. I was not able to sleep following the treatments and it did not provide any back relief. I have discontinued treatment and will be making an appointment with a psychiatrist tomorrow.

Plan of Action

response via email  
Dell Inc  
09/19/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: [www.aetnadisability.com](http://www.aetnadisability.com)

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Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Inquiry Analysis:	Other
Details of Inquiry:	
Response Analysis:	Customer Service response
Details of Response:	
Response Method:	Reply via email

Follow Up SSDI Review Task	9/19/14	Closed	9/19/14 9:05 am	SHARON RAND	SHARON RAND	SHARON RAND	9/19/14 9:05 am
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Social Security Type	Disability
Social Security Type	Disability
Level	New Claim
Level	Monitoring
Status	Pending
Status	Pending
Status Date	1/1/0001 12:00:00 AM
Status Date	5/13/2014 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Individual Amount	0
Individual Amount	0
Add'l Earnings Amount	0
Add'l Earnings Amount	0
Dependent Amount	0

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Dependent Amount	0
Notes:	Allsup Review: Allsup SSC accepting for SSDI representation. Claim forwarded to Allsup for further review and to mail intro packet.
Plan of Action:	see above.

Follow Up SSDI Review Task	9/24/14	Closed	9/24/14 10:20 am	FRANCES GARCIA	FRANCES GARCIA	FRANCES GARCIA	9/24/14 10:20 am
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Social Security Type	Disability
Social Security Type	Disability
Social Security Type	Disability
Level	New Claim
Level	Monitoring
Level	New Claim
Status	Pending
Status	Pending
Status	Pending
Status Date	1/1/0001 12:00:00 AM
Status Date	5/13/2014 12:00:00 AM
Status Date	9/19/2014 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Individual Amount	0

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Individual Amount	0
Individual Amount	0
Add'l Earnings Amount	0
Add'l Earnings Amount	0
Add'l Earnings Amount	0
Dependent Amount	0
Dependent Amount	0
Dependent Amount	0
Notes:	Allsup introductory package offering representation was mailed 09/22/2014. Allsup will follow up for a signed SSA 1696.
Plan of Action:	SEE NOTE

Correspondence - Outgoing	9/22/14	Closed	9/26/14 1:01 pm	SHAWNDR A LEE	ASHUTOSH NARAYAN SINGH	SHAWNDR A LEE	9/26/14 1:01 pm
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Image Description: LETTER

Image Notes: Allsup Letter

Email Response to Member	9/30/14	Closed	9/30/14 3:25 pm	MARIE ANELAS	MARIE ANELAS	MARIE ANELAS	9/30/14 3:25 pm
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To Address List: **REDACTED**

CC Address List:

Do Not Send No

Comments:

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Report Date: 10/06/2015



Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Email From Member	9/30/14	Closed	9/30/14 3:27 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	MARIE ANELAS	9/30/14 3:27 pm
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Member Home Email Address

**REDACTED**

Date and Time Submitted

9/30/2014 11:41:05 AM

Question Category selected

My Claim

Question Submitted

Good morning I would like to update my information concerning my phone conversation this morning. I have been following the Physical Therapy recommendations. I try to exercise, or stretch everyday but sometimes it is too painful. It was recommended to use the Elliptical machine versus a treadmill because the treadmill would be too stressful for my back. Using Tramadol and Arthritis Strength Tylenol I can normally use the machine for 20 minutes. I do my shoulder therapy exercises and I do my stretching at home. I believe the mental therapy will be helpful for my pain. When I first started the Cymbalta I was able to sleep 5-6 hours at night and did not experience burning in my feet all day. Now it appears I have to continue to increase the dosage for relief

I believe the mental therapy will help me sleep and I am hopeful a better disposition, attitude and feeling of selfworth will help my daily life. I have become frustrated with medical and chiropractic relief claims but I will not give up hope of recovery.

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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#### Plan of Action

E-mail respond to member:

PLEASE DO NOT REPLY  
This mailbox is not monitored on a daily basis.  
If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
09/30/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: [www.aetnadisability.com](http://www.aetnadisability.com)

Claim status

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Details of Response:

Response Method:

Customer Service response

Reply via email

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
Correspondence - Incoming	9/29/14	Closed	9/30/14 10:38 am	SHAWNDR LEE	YADAV VIKAS	SHAWNDR LEE	9/30/14 10:38 am

Image Description: CORR

Image Notes: Denial letter from SSI

Email Response to Member	10/3/14	Closed	10/3/14 5:52 am	DOMINICA TAYLOR	DOMINICA TAYLOR	DOMINICA TAYLOR	10/3/14 5:52 am
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To Address List: **REDACTED**

CC Address List:

Do Not Send: No

Comments:

Email From Member	10/2/14	Closed	10/3/14 5:53 am	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	DOMINICA TAYLOR	10/3/14 5:53 am
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Member Home Email Address: **REDACTED**

Date and Time Submitted: 10/2/2014 2:24:37 PM

Question Category selected: Other

Question Submitted: Sorry I did not finish my last message. I am in pain doing my PT. I normally take Tramadol and 2 Arthritis Strength Tylenol, so I should complete class, ice my back and prop up my legs. The true benefits will be enjoying doing something, getting out of the house and not focusing on my pain for a bit.

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action

email response

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.  
Claim management process

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Customer Service response

Details of Response:

Response Method:

Reply via email

Follow Up SSDI Review Task	10/30/14	Closed	10/30/14 10:51 am	FRANCES GARCIA	FRANCES GARCIA	FRANCES GARCIA	10/30/14 10:51 a
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Social Security Type

Disability

Social Security Type

Disability

Social Security Type

Disability

Level

New Claim

Level

Monitoring

Level

New Claim

Status

Pending

Status

Pending

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Status	Pending
Status Date	1/1/0001 12:00:00 AM
Status Date	5/13/2014 12:00:00 AM
Status Date	9/19/2014 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Individual Amount	0
Individual Amount	0
Individual Amount	0
Add'l Earnings Amount	0
Add'l Earnings Amount	0
Add'l Earnings Amount	0
Dependent Amount	0
Dependent Amount	0
Dependent Amount	0
Notes:	Appointment of Representation/Authorization forms received by Allsup 10/22/2014. Allsup will schedule interview with the claimant.
	Claimant had filed for SSDI and was denied at the Initial level. Allsup will review for reconsideration appeal.
Plan of Action:	SEE NOTE

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
LTD - Claimant Survey 1	11/3/14	Closed	11/3/14 9:05 am	SHAWNDR LEE	WKAB SYSTEM	SHAWNDR LEE	11/3/14 9:05 am

AutoCall Choices: Yes, Send Call

If 'No, do not send call', provide the following drop down selection:

If Other is selected, provide reason:

LTD Claimant Interview	11/3/14	Closed	11/6/14 1:20 pm	SHAWNDR LEE	WANDA GREENE-CELESTINE	SHAWNDR LEE	11/6/14 1:20 pm
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Completed Contact Type: Employee

If Attorney or "Other"

Please define:

Notes

DBM contacted EE to get a better understanding of EE's oow condition. DBM inquired if EE was treating with chiro that he mention in email sent on 09/19/2014. EE informed that he is no longer treating with chiro. EE stated that the spinal deep compression was no good. EE advised that he will be treating with therapist (Jonathan Gish) first OV will be the second week of October. EE will also treat with psychiatrist ( Dr. Steven Nyquist) on 10/13/2014. DBM asked EE what is the condition preventing him from returning to work. EE informed the pain and burning in his feet.

EE will be treating with PCP on 10/02/2014. EE informed that his cymbalta has been increase to 90 mg. EE states that he has difficulty with sleeping due to the pain that radiates from his feet to his back. EE informed that he can not sit for prolong period of time due to pain in feet and back. EE states that he can sit for 6-7 minutes before pain. EE advise that he does use the computer a total of 15 minutes a day. EE is capable of drive however only drives to take his son to school. EE states that he attends church but have difficulty with sitting. EE informed that EE has assistance with showering from his ex-wife. EE does nto cook.

DBM inquired about classes EE informed that EE would take in the fall at MTSU. EE informed that he has not begin classes but may go in January 2015. EE has been denied. (See More)

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Early Any Occupation Assessment	*
Plan of Action	DBM will request medicals from treating providers
	DBM will update LTD action plan

Faxed Form Request	11/6/14	Closed	11/6/14 2:15 pm	SHAWNDR LEE	SHAWNDR LEE	SHAWNDR LEE	11/6/14 2:15 pm
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Mailing Method: USPS

Comments:

Faxed Form Request	11/6/14	Closed	11/6/14 2:26 pm	SHAWNDR LEE	SHAWNDR LEE	SHAWNDR LEE	11/6/14 2:26 pm
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Mailing Method: USPS

Comments:

Fax Form Confirmation Task	11/6/14	Closed	11/6/14 2:26 pm	SHAWNDR LEE	SHAWNDR LEE	SHAWNDR LEE	11/6/14 2:26 pm
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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Please enter the internal work note.

-----Original Message-----  
 From: Service ID DeliveryWare Fax  
 Sent: Thursday, November 06, 2014 2:02 PM  
 To: Lee, Shawndra E  
 Subject: Job ID 123085351 sent to Dr. Steven Nyquist; Status (success)

Your fax was successfully sent to Dr. Steven Nyquist.

Fax number: 615-771-1109  
 Subject: Re: Arthur Davis **REDACTED**  
 Status: (success)  
 Completed: 2:02:01 PM, Thursday, November 06, 2014 Sent pages: 5 of 5  
 Duration: 0:02:02  
 Account: GDV GI DIS TPA MIXED 1  
 ID: A241118  
 Received CSID: 615+771+1109  
 JOBID: 123085351

Fax Form Confirmation Task	11/6/14	Closed	11/6/14 2:27 pm	SHAWNDR LEE	SHAWNDR LEE	SHAWNDR LEE	11/6/14 2:27 pm
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Report Date: 10/06/2015



Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Please enter the internal work note.

-----Original Message-----  
 From: Service ID DeliveryWare Fax  
 Sent: Thursday, November 06, 2014 2:27 PM  
 To: Lee, Shawndra E  
 Subject: Job ID 123089534 sent to Dr. Tad Yoneyama; Status (success)

Your fax was successfully sent to Dr. Tad Yoneyama.

Fax number: 615-916-3903  
 Subject: Re: Arthur Davis **REDACTED**  
 Status: (success)  
 Completed: 2:26:38 PM, Thursday, November 06, 2014 Sent pages: 3 of 3  
 Duration: 0:00:42  
 Account: GDV GI DIS TPA MIXED 1  
 ID: A241118  
 Received CSID: 16159163903  
 JOBID: 123089534

Analysis/Review Medical Records	11/6/14	Closed	11/7/14	9:47 am	SHAWNDR A LEE	WEB SERVICE	SHAWNDR A LEE	11/7/14	9:47 am
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Image Description	Blank APS
Image Notes	
Date Medical Received	11/06/2014
Type of Information Recd-select all that apply	APS
If Other Information Received, please describe:	
Provider Name:	blank forms
Diagnosis:	Other
If Other, please specify:	ROTATOR CUFF (CAPSULE) SPRAIN

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Report Date: 10/06/2015

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Was a new disabling condition noted in the medical records received?	No
CPT Search:	
CPT Code	23420
CPT4 Description	RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)
Procedure Date:	1/31/2014
Date of Disability:	10/9/2013
RTW Date (if provided):	
Notes	APS was returned blank
Plan of Action	DBM will f/u with EE for update Auth
CPT Code	29822
CPT Code	29822
CPT Code	29826
CPT Code	29827
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Analysis/Review Medical Records	11/6/14	Closed	11/7/14 9:49 am	SHAWNDR LEE	YADAV VIKAS	SHAWNDR LEE	11/7/14 9:49 am
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Image Description	MED
Image Notes	
Date Medical Received	11/06/2014
Type of Information Recd-select all that apply	APS
If Other Information Received, please describe:	
Provider Name:	blank forms
Diagnosis:	Other
If Other, please specify:	ROTATOR CUFF (CAPSULE) SPRAIN
Was a new disabling condition noted in the medical records received?	No
CPT Search:	
CPT Code	23420
CPT4 Description	RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)
Procedure Date:	1/31/2014
Date of Disability:	10/9/2013
RTW Date (if provided):	
Notes	Received blank form
Plan of Action	DBM will forward Auth to provider office
CPT Code	29822
CPT Code	29822
CPT Code	29826

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT Code	29827
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

Follow Up SSDI Review Task	11/19/14	Closed	11/19/14	4:35 pm	MARY JO HEBERT	MARY JO HEBERT	MARY JO HEBERT	11/21/14	1:50 p
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Social Security Type	Disability
Social Security Type	Disability
Social Security Type	Disability
Social Security Type	Disability
Level	New Claim
Level	Monitoring
Level	New Claim
Level	Initial
Status	Pending
Status	Pending

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Status	Pending
Status	Pending
Status Date	1/1/0001 12:00:00 AM
Status Date	5/13/2014 12:00:00 AM
Status Date	9/19/2014 12:00:00 AM
Status Date	10/30/2014 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Individual Amount	0
Individual Amount	0
Individual Amount	0
Individual Amount	0
Add'l Earnings Amount	0
Add'l Earnings Amount	0
Add'l Earnings Amount	0
Add'l Earnings Amount	0
Dependent Amount	0
Dependent Amount	0
Dependent Amount	0
Dependent Amount	0

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Notes:	ALLSUP CONDUCTED THE INITIAL CLAIM INTERVIEW 11-04-2014. ALLSUP HAS FORWARDED THE IC FORMS TO THE CLAIMANT FOR SIGNATURE. MJH
Plan of Action:	SEE NOTE

Fax Form Confirmation Task	11/21/14	Closed	11/21/14 2:44 pm	SHAWNDR A LEE	SHAWNDR A LEE	SHAWNDR A LEE	11/21/14 2:44 p
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Please enter the internal work note.

-----Original Message-----  
 From: Service ID DeliveryWare Fax  
 Sent: Friday, November 21, 2014 2:00 PM  
 To: Lee, Shawndra E  
 Subject: Job ID 124482659 sent to Dr. Steven Nyquist; Status (success)

Your fax was successfully sent to Dr. Steven Nyquist.

Fax number: 615-771-1109  
 Subject: Re: Arthur Davis **REDACTED**  
 Status: (success)  
 Completed: 2:00:23 PM, Friday, November 21, 2014 Sent pages: 9 of 9  
 Duration: 0:03:42  
 Account: GDV GI DIS TPA MIXED 1  
 ID: A241118  
 Received CSID: 615+771+1109  
 JOBID: 124482659

Analysis/Review Medical Records	11/21/14	Closed	11/24/14 9:11 am	SHAWNDR A LEE	ANKESH KUMAR	SHAWNDR A LEE	11/24/14 9:11 a
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Image Description	Analysis/Review Medical Records
Image Notes	
Date Medical Received	11/21/2014

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Type of Information Recd-select all that apply	Other
If Other Information Received, please describe:	return form
Provider Name:	Dr. Steven Nquist
Diagnosis:	Other
If Other, please specify:	ROTATOR CUFF (CAPSULE) SPRAIN
Was a new disabling condition noted in the medical records received?	No
CPT Search:	
CPT Code	23420
CPT4 Description	RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)
Procedure Date:	1/31/2014
Date of Disability:	10/9/2013
RTW Date (if provided):	
Notes	DBM received return request from Dr. Nquist office stating new pt's signature.
Plan of Action	DBM will f/u with EE regarding ppw from Dr. Nquist office.
CPT Code	29822
CPT Code	29822
CPT Code	29826
CPT Code	29827
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

Free Form Letter STD-LTD	11/24/14	Closed	11/24/14 10:55 am	SHAWNDR A LEE	SHAWNDR A LEE	SHAWNDR A LEE	11/24/14 10:55 a
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Mailing Method:	USPS
Do Not Send	No
Comments:	

Email Response to Member	12/5/14	Closed	12/5/14 7:03 pm	MARIE ANELAS	MARIE ANELAS	MARIE ANELAS	12/8/14 8:16 am
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To Address List:	<b>REDACTED</b>
CC Address List:	
Do Not Send	No
Comments:	

Email From Member	12/5/14	Closed	12/5/14 7:04 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	MARIE ANELAS	12/8/14 8:16 am
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Member Home Email Address	<b>REDACTED</b>
Date and Time Submitted	12/5/2014 12:47:25 PM
Question Category selected	My Claim

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Report Date: 10/06/2015



Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Question Submitted

Good afternoon I was seen by my Nuerologist Dr Paul Buechel of KCA Nuerology 4323 Carothers Pkwy, Franklin, TN 37067 (615) 550-1800

Dr Buechel seems to have determined what is causing my Back pain and feet numbing and pain. The new MRI shows Bone Spurs that are inoperatable. When the spurs press on a nerve, I am in pain or develop numbness or pain in my feet. I saw the letter addressed to me online. Dr Nyquist and Yanoyamo will update information but they probably will not do any kind of Disability determination. I will contact their offices to request information updates. I was also seen by Dr. James Renfro concerning some right shoulder complications. I will be participating in physical therapy for the next three weeks and sucess or failure will determine if additional surgery is required. I am available at anytime for a follow up call.

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action

E-mail respond to member:

PLEASE DO NOT REPLY  
This mailbox is not monitored on a daily basis.  
If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
12/05/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager along with a request to call you.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>  
Claim status

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Details of Response:

Response Method:

Customer Service response

Reply via email

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Free Form Letter STD-LTD	12/9/14	Closed	12/9/14 9:14 am	SHAWNDR LEE	SHAWNDR LEE	SHAWNDR LEE	12/9/14 9:15 am
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Mailing Method: USPS

Do Not Send No

Comments:

Email Response to Member	12/19/14	Closed	12/19/14 9:30 am	LATONYA WALLACE	LATONYA WALLACE	LATONYA WALLACE	12/19/14 9:30 am
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To Address List: **REDACTED**

CC Address List:

Do Not Send No

Comments:

Email From Member	12/18/14	Closed	12/19/14 9:30 am	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	LATONYA WALLACE	12/19/14 9:30 am
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Member Home Email Address **REDACTED**

Date and Time Submitted 12/18/2014 11:30:35 PM

Question Category selected Other

Question Submitted I spoke to a representative today and was told that my doctors had been faxed information. I requested a copy to print out for my doctors and was told it would be on Dashboard. I will go to their offices tomorrow.

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager. Once that information is received your Claim Manager will review the information and send you a confirmation letter with the details about your claim, once the review has been completed.

Please let us know if we can provide additional assistance.

Forms

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Customer Service response

Details of Response:

Response Method:

Reply via email

Analysis/Review Medical Records	12/23/14	Closed	12/23/14	1:54 pm	SHAWNDR A LEE	SANJAY KUMAR	SHAWNDR A LEE	12/23/14	1:54 p
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Image Description

MED DOC

Image Notes

Date Medical Received

12/23/2014

Type of Information Recd-select all that apply

200002|200003

If Other Information Received, please describe:

Provider Name:

Dr.Paul Buechel

Diagnosis:

Other

If Other, please specify:

DISTURBANCE OF SKIN SENSATION

Was a new disabling condition noted in the medical records received?

No

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT Search:

CPT Code 23420

CPT4 Description RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)

Procedure Date: 1/31/2014

Date of Disability: 10/9/2013

RTW Date (if provided):

Notes DBM received OVN from 10/2014 and 12/2014 from Dr. Buechel and MRI report from 11/6/2014.

Plan of Action DBM will have SNR review claim with updated medicals

CPT Code 29822

CPT Code 29822

CPT Code 29826

CPT Code 29827

CPT4 Description ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

CPT4 Description ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED

CPT4 Description ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY

CPT4 Description ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR

Procedure Date: 10/11/2013

Procedure Date: 1/31/2014

Procedure Date: 10/11/2013

Procedure Date: 10/11/2013

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Email Response to Member	12/23/14	Closed	12/23/14 4:19 pm	SHERRI MCINNES	SHERRI MCINNES	SHERRI MCINNES	12/24/14 10:18 a
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To Address List: **REDACTED**

CC Address List:

Do Not Send No

Comments:

Email From Member	12/23/14	Closed	12/23/14 4:19 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB MOBILE	SHERRI MCINNES	12/24/14 10:18 a
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Member Home Email Address **REDACTED**

Date and Time Submitted 12/23/2014 12:03:31 PM

Question Category selected Other

Question Submitted I just spoke to Dr Yaneyama office they said the have sent information. I was not seen on the dates requested. I was referred to Dr Buechel and my next appointment is in January for Dr Yaneyama. I have asked them to send an update.

Plan of Action Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Claim status

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Customer Service response

Details of Response:

Response Method:

Reply via email

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
Faxed Form Request	12/23/14	Closed	12/23/14 12:05 pm	LUIS ALCALA	LUIS ALCALA	LUIS ALCALA	12/23/14 1:43 p

Mailing Method: USPS

Comments:

Correspondence - Incoming	12/26/14	Closed	12/26/14 11:06 am	SHAWNDR A LEE	ROHIT SINGH		12/26/14 11:06 a
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Image Description: corr

Image Notes: request of medical auth from provider

Email Response to Member	12/29/14	Closed	12/29/14 8:59 am	DOMINICA TAYLOR	DOMINICA TAYLOR	DOMINICA TAYLOR	12/29/14 8:59 a
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To Address List: **REDACTED**

CC Address List:

Do Not Send No

Comments:

Email From Member	12/29/14	Closed	12/29/14 9:02 am	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB MOBILE	DOMINICA TAYLOR	12/29/14 9:02 a
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Member Home Email Address **REDACTED**

Date and Time Submitted 12/28/2014 6:30:05 PM

Question Category selected My Claim

Question Submitted I am about to drop COBRA and wanted to make sure I do not need COBRA To continue my LTD benefits.

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action

email response

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Cobra is the continuation of your medical or dental benefits. Long Term Disability benefits are not affected by COBRA.

Please let us know if we can provide additional assistance.  
Benefits questions

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Details of Response:

Response Method:

Customer Service response

Reply via email

Fax Form Confirmation Task	12/23/14	Closed	12/31/14	8:49 am	LUIS ALCALA	LUIS ALCALA	LUIS ALCALA	1/7/15	8:35 am
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Report Date: 10/06/2015



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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Please enter the internal work note.

Your fax was successfully sent to Dr. Tad Yoneyama Heritage Medical.

Fax number: 6159163903  
 Subject: MR. ARTHUR DAVIS  
 Status: (success)  
 Completed: 12:09:09 PM, Tuesday, December 23, 2014 Sent pages: 3 of 3  
 Duration: 0:00:46  
 Account: ASO SO LRB DI TAMPA CSR  
 ID: A304170  
 Received CSID: 16159163903  
 JOBID: 127101337

Email Response to Member	1/7/15	Closed	1/7/15 8:13 am	SHERRI MCINNES	SHERRI MCINNES	SHERRI MCINNES	1/7/15 8:35 am
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To Address List:

**REDACTED**

CC Address List:

Do Not Send

No

Comments:

Email From Member	1/6/15	Closed	1/7/15 8:14 am	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	SHERRI MCINNES	1/7/15 8:35 am
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Member Home Email Address

**REDACTED**

Date and Time Submitted

1/6/2015 6:14:35 PM

Question Category selected

Other

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Question Submitted

I have been having problems with my right shoulder the past three months. On December 5th, 2014 I was seen by my Orthopedic Doctor James Renfro. Dr. Renfro took an xray and diagnosed Inflamed AC Joint. Three sessions of PT was suggested, I completed but was still in pain. I received a Cortizone injection in my shoulder on December 26th, 2014. I am still having issues but I am trying to strengthen my shoulder with exercise. I am having extreme pain if I lie on my right shoulder, I cannot lift heavy items and I having shooting pains at times.

Plan of Action

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Claim status

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Referred to claim owner

Details of Response:

Response Method:

Reply via email

Job Desc/Job Analysis	1/8/15	Closed	1/9/15 8:22 am	SHAWNDR LEE	ARUN CHAWLA	SHAWNDR LEE	1/9/15 8:22 am
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Image Description:

JD

Image Notes:

JO description

Termination - Various Reasons (STD/LTD)	1/12/15	Closed	1/12/15 2:14 pm	WANDA GREENE-CELESTINE	SHAWNDR LEE	WANDA GREENE-CELESTINE	1/12/15 2:14 pm
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Mailing Method:

USPS

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Do Not Send No

Comments:

Benefit Level Authority Review	1/12/15	Closed	1/12/15 2:48 pm	WANDA GREENE-CELESTINE	SHAWNDR LEE	WANDA GREENE-CELESTINE	1/12/15 2:49 pm
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Please enter the internal work note. approval limit exceeded Benefit Level Authority Review created

Authority Review Completed	1/12/15	Closed	1/12/15 3:50 pm	SHAWNDR LEE	WANDA GREENE-CELESTINE	SHAWNDR LEE	1/13/15 8:50 am
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Please enter the internal work note. Authority Review Completed task created

LTD Disability Determination	1/12/15	Closed	1/12/15 11:36 am	WANDA GREENE-CELESTINE	SHAWNDR LEE	WANDA GREENE-CELESTINE	1/12/15 11:36 am
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Disability Date: 10/9/2013 12:00:00 AM

Benefit Begin Date: 4/7/2014 12:00:00 AM

Has claimant eligibility been confirmed? Yes

Is this a pre-existing condition? No

If Yes, what is the date of last treatment?

Have you reviewed for potential plan/policy exclusions? Yes

Have all applicable offsets been applied? Yes

Has the functionality vs. job requirements been addressed before disability determination? Yes

Do objective/clinical findings support ongoing disability? No

Is the claimant disabled per plan/policy definition of disability? No

Disability Determination Terminate

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Tier:	Tier 3
Work Capacity	No Current Work Capacity
Rationale for decision:	<p>FDA:10/9/2013 LTD: 4/7/2014 EE CO-MORBIDS: Diabetes, HTN, GERD</p> <p>EE IS a 51Y/O male INSIDE SALES ACCT MGMT III, WHO WENT ON LEAVE AS OF 10/09/2013 DUE TO DX OF ROTATOR CUFF REPAIR. Rotator Cuff Repairs on 10/11/2013 &amp; 1/31/14.</p> <p>Job Requirements: EE IS REQUIRED TO SIT THE MAJORITY OF HIS WORK DAY, NO LIFTING IS REQUIRED. EE IS REQUIRED TO HAVE THE ABILITY TO FOLLOW DIRECTIONS AND ROUTINES, PLAN AND ORGANINZE, AND ANALYZE DATA.</p> <p>MEDICAL INFORMATION FROM DR. PAUL BUECHEL ON 12/23/2014 INFORMED THAT EE C/O LOW BACK PAIN. HOWEVER THERE WERE NO EXAM FINDINGS THAT WOULD SUPPORT IMPAIRMENT FROM EE OWN SEDENTARY OCCUPATION.</p>
Plan of Action:	<p>AT THIS TIME LTD CLAIM WILL BE TERMED DUE TO INSUFFICIENT MEDICAL INFORMATION. TERM BENEFITS AS OF 1/08/2015 DUE TO INSUFFICIENT MEDICAL INFORMATION TO SUPPORT CLAIM</p> <p>FORWARD TO STS FOR SIGN OFF ON TERM.</p> <p>INFORMEE OF CLAIM STATUS</p>
Comments	

LTD Determination EE Contact	1/12/15	Closed	1/12/15 12:36 pm	SHAWNDRRA LEE	WANDA GREENE-CELESTINE	SHAWNDRRA LEE	1/12/15 12:36 pm
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Contact Type: Employee

If other, please specify:

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Report Date: 10/06/2015

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Disability Determination:	Terminate
Plan of Action:	DBM contacted EE and advised him of claim status.
	DBM also informed EE of ERISA rights
	Close has been updated and closed.
Contact Outcome:	Completed

Employer Contact Email	1/12/15	Closed	1/12/15 12:40 pm	SHAWNDR LEE	SHAWNDR LEE	SHAWNDR LEE	1/12/15 12:40 pm
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To Address List:	Ungerj@aetna.com, us_leave_administrator@dell.com
CC Address List:	
Do Not Send	No
Comments:	

Analysis/Review Medical Records	1/12/15	Closed	1/13/15 8:53 am	SHAWNDR LEE	ANIL KUMAR	SHAWNDR LEE	1/13/15 8:53 am
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Image Description	DR
Image Notes	
Date Medical Received	01/12/2015
Type of Information Recd-select all that apply	Other
If Other Information Received, please describe:	Incoming correspondence
Provider Name:	Dr. Nquist
Diagnosis:	Other
If Other, please specify:	DISTURBANCE OF SKIN SENSATION

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Was a new disabling condition noted in the medical records received?	No
CPT Search:	
CPT Code	23420
CPT4 Description	RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)
Procedure Date:	1/31/2014
Date of Disability:	10/9/2013
RTW Date (if provided):	
Notes	DBM received incoming correspondence.
Plan of Action	Claim closed.
CPT Code	29822
CPT Code	29822
CPT Code	29826
CPT Code	29827
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY
CPT4 Description	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR
Procedure Date:	10/11/2013
Procedure Date:	1/31/2014
Procedure Date:	10/11/2013
Procedure Date:	10/11/2013

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Medical Authorization Form	1/12/15	Closed	1/13/15 8:55 am	SHAWNDR LEE	ANIL KUMAR	SHAWNDR LEE	1/13/15 8:55 am
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Please enter the Image Notes:	MED
Medical Release Status:	No - Duplicate/Incorrect Form
Medical Release Image #:	16647939
Date Medical Release Signed	02/11/2014
Do you want to update the Forms tab?	No

Correspondence - Incoming	1/14/15	Closed	1/14/15 4:27 pm	SHAWNDR LEE	BHUPENDRA SINGH	SHAWNDR LEE	1/14/15 4:27 pm
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Image Description:	SSA
Image Notes:	Notice of Reconsideration from SSDI

Follow Up SSDI Review Task	1/14/15	Closed	1/14/15 12:43 pm	FRANCES GARCIA	FRANCES GARCIA	FRANCES GARCIA	1/14/15 12:43 pm
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Social Security Type	Disability
Social Security Type	Disability
Social Security Type	Disability
Social Security Type	Disability
Level	New Claim
Level	Monitoring
Level	New Claim
Level	Initial

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Status	Pending
Status	Pending
Status	Pending
Status	Pending
Status Date	1/1/0001 12:00:00 AM
Status Date	5/13/2014 12:00:00 AM
Status Date	9/19/2014 12:00:00 AM
Status Date	10/30/2014 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Individual Amount	0
Individual Amount	0
Individual Amount	0
Individual Amount	0
Add'l Earnings Amount	0
Add'l Earnings Amount	0
Add'l Earnings Amount	0
Add'l Earnings Amount	0
Dependent Amount	0
Dependent Amount	0

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Dependent Amount	0
Dependent Amount	0
Notes:	The claimant was denied SSDI at the Reconsideration level 01/09/2015. Allsup will review to file an appeal to the Administrative Law Judge.
Plan of Action:	Allsup provided SSDI Reconsideration Denial letter to Aetna via email fax to BES. See Note

Correspondence - Appeals	1/23/15	Closed	1/29/15 3:26 pm	NA APPEAL QUEUE USER 1	SAURABH GUPTA	CANDICE HOY	1/29/15 3:26 pm
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Image Description: APPEAL LETTER

Image Notes:

AppealAcknowledgment <del>Letter Incomplete</del>	1/29/15	Closed	1/29/15 3:27 pm	CANDICE HOY	CANDICE HOY	CANDICE HOY	1/29/15 3:27 pm
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Mailing Method: USPS

Do Not Send: No

Comments:

AppealAcknowledgmentEmail-inco <del>mplete</del>	1/29/15	Closed	1/29/15 3:29 pm	CANDICE HOY	CANDICE HOY	CANDICE HOY	1/29/15 3:29 pm
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To Address List: STD\_LOA@aetna.com,SUSAN\_PARKER@DELL.COM, Julie\_Lundquist@Dell.com

CC Address List:

Do Not Send: No

Comments:

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Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Correspondence - Appeals	1/29/15	Closed	2/2/15 1:41 pm	NA APPEAL QUEUE USER 1	YADAV VIKAS	BEVERLY SMART	2/2/15 1:41 pm
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Image Description: Appeal letter

Image Notes:

Appeal Triage Review	1/29/15	Closed	2/2/15 9:31 am	SHAWNDR LEE	CANDICE HOY	SHAWNDR LEE	2/2/15 9:31 am
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Plan Name	DD
ERISA	Yes
Funding Type	Insured
Appeal ID	11345031
Level of Appeal	Final
Reason for Claim Denial/Termination	Disability Not Supported
Job Title	INSIDE SALES ACCOUNT MGMT III
First Day Absent	10/9/2013 12:00:00 AM
Benefit Begin Date	4/7/2014 12:00:00 AM
Approved Start Date	4/7/2014 12:00:00 AM
Approved Thru Date	1/11/2015 12:00:00 AM
Date Benefit Denied/Terminated	1/12/2015 12:00:00 AM
Appeal Review Comments	Medical information does not support
Appeal Triage Determination	Claim Returned to Appeals Unit

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Follow Up SSDI Review Task	2/3/15	Closed	2/3/15 9:07 am	FRANCES GARCIA	FRANCES GARCIA	FRANCES GARCIA	2/3/15 9:07 am
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Social Security Type	Disability
Social Security Type	Disability
Social Security Type	Disability
Social Security Type	Disability
Level	New Claim
Level	Monitoring
Level	New Claim
Level	Initial
Status	Pending
Status	Pending
Status	Pending
Status	Pending
Status Date	1/1/0001 12:00:00 AM
Status Date	5/13/2014 12:00:00 AM
Status Date	9/19/2014 12:00:00 AM
Status Date	10/30/2014 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM
Entitlement Date	1/1/0001 12:00:00 AM

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Individual Amount	0
Individual Amount	0
Individual Amount	0
Individual Amount	0
Add'l Earnings Amount	0
Add'l Earnings Amount	0
Add'l Earnings Amount	0
Add'l Earnings Amount	0
Dependent Amount	0
Dependent Amount	0
Dependent Amount	0
Dependent Amount	0
Notes:	Allsup has closed claim because the claim was closed at Aetna. If the claim is reinstated, please notify Allsup by generating a new "Initial SSDI Review Task" for Allsup.
Plan of Action:	SEE NOTE

AppealAssignment	2/2/15	Closed	2/3/15 10:05 am	NA CENTRALIZED APPEAL UNIT QUEUE USER 1	SHAWNDRA LEE	DANIEL BERTRAND	2/4/15 9:21 am
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Plan Name:	DD
ERISA:	Yes
Funding Type:	Insured
Appeal ID:	11345031
Appeal Level:	
Final Fiduciary:	Aetna

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Reason for Claim Denial/Termination: Disability Not Supported  
Assigned To: 12422345

Appeal Follow Up for Triage	2/3/15	Closed	2/4/15 9:22 am	CANDICE HOY	CANDICE HOY	CANDICE HOY	2/4/15 9:22 am
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Appeal ID: 11345031  
Comments: Appeal Triage Review task completed as claim returned to Appeals.

Email Response to Member	2/20/15	Closed	2/20/15 10:47 am	THEODORA WILLIAMS	THEODORA WILLIAMS	THEODORA WILLIAMS	2/20/15 10:47 am
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To Address List: **REDACTED**  
CC Address List:  
Do Not Send: No  
Comments:

Email From Member	2/19/15	Closed	2/20/15 10:47 am	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	THEODORA WILLIAMS	2/20/15 10:47 am
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Member Home Email Address: **REDACTED**  
Date and Time Submitted: 2/19/2015 3:15:56 PM  
Question Category selected: My Appeal  
Question Submitted: Does Aetna need any additional information? Have you received medical records requested?

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Report Date: 10/06/2015

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action

email response to member

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

We received the Authorization to Request Protected Health Information, the Disability Appeal Request Form and your medical records for review on 02/09/2015. We will send you a confirmation letter with the details about your claim, once the review has been completed.

Please let us know if we can provide additional assistance.

Inquiry Analysis:

Was Paperwork received

Details of Inquiry:

Response Analysis:

Customer Service response

Details of Response:

Response Method:

Reply via email

Initial Appeal EE Contact Task	2/3/15	Closed	2/24/15 1:55 pm	CHARLAI LANG	DANIEL BERTRAND	CHARLAI LANG	2/24/15 1:55 pm
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Plan Name:

DD

ERISA:

Yes

Funding Type:

Insured

Appeal ID:

11345031

Appeal Level:

Final

Final Fiduciary:

Aetna

Reason for Claim Denial/Termination:

Disability Not Supported

Contact Type:

Employee

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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If Other, please specify:

Initial EE Contact Attempt 1 Date:

02/24/2015

Contact Outcome:

Left VMM

Time:

12:07

Notes:

A/S left vm to determine if additional information is forthcoming or the 1-24-15 note is the all the new info to be used to evaluate the ee's continued issues with sedentary work capacity

Initial EE Contact Attempt 2 Date:

Contact Outcome:

Time:

:00

Notes:

Initial EE Contact Attempt 3 Date

Contact Outcome:

Time:

:00

Notes:

EE's description of job duties:

Last Day Worked:

10/8/2013 12:00:00 AM

First Day Absent:

10/9/2013 12:00:00 AM

Disability Date:

10/9/2013 12:00:00 AM

Approved Start Date:

4/7/2014 12:00:00 AM

Approved Through Date:

1/11/2015 12:00:00 AM

Released To RTW:

Actual RTW:

1/1/0001 12:00:00 AM

Diagnosis Information:

3155

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
ICD Code Type				ICD9			
ICD Code Type				ICD9			
ICD Code Type				ICD9			
ICD Code Type				ICD9			
ICD Code Type				ICD9			
ICD Code				782.0			
ICD Code				724.2			
ICD Code				722.52			
ICD Code				724.4			
ICD Code				355.71			
ICD Description				DISTURBANCE OF SKIN SENSATION			
ICD Description				LUMBAGO			
ICD Description				DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC			
ICD Description				THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS, UNSPECIFIED			
ICD Description				CAUSALGIA OF LOWER LIMB			
CPT4 Code				23420			
CPT4 Code				29822			
CPT4 Code				29822			
CPT4 Code				29826			
CPT4 Code				29827			
CPT4 Description				RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)			
CPT4 Description				ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED			

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Report Date: 10/06/2015



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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CPT4 Description					ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED		
CPT4 Description					ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY		
CPT4 Description					ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR		
Procedure Date					1/31/2014 12:00:00 AM		
Procedure Date					10/11/2013 12:00:00 AM		
Procedure Date					1/31/2014 12:00:00 AM		
Procedure Date					10/11/2013 12:00:00 AM		
Procedure Date					10/11/2013 12:00:00 AM		
First Name					Brenna		
First Name					Dr. Nicholas		
First Name					JAMES		
First Name					Jason		
First Name					SUBIR		
Last Name					Green		
Last Name					Cote		
Last Name					RENFRO		
Last Name					Knox		
Last Name					PRASAD		
Speciality					Physical Med & Rehab/Pain Management		
Speciality					Orthopedic Surgery		
Speciality					Orthopedic Surgery		
Speciality					Podiatry		

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Speciality	Neurology
Last Office Visit	5/6/2014 12:00:00 AM
Last Office Visit	1/1/0001 12:00:00 AM
Last Office Visit	1/1/0001 12:00:00 AM
Last Office Visit	1/1/0001 12:00:00 AM
Last Office Visit	5/29/2014 12:00:00 AM
Next Office Visit	6/11/2014 12:00:00 AM
Next Office Visit	1/1/0001 12:00:00 AM
Next Office Visit	4/26/2014 12:00:00 AM
Next Office Visit	1/1/0001 12:00:00 AM
Next Office Visit	1/1/0001 12:00:00 AM
Phone Number	615-867-7971
Phone Number	615-893-4480
Phone Number	615-834-4482
Phone Number	615-220-8788
Phone Number	615-425-7605

Notes:

Confirm Treatment Plan:

Review all medical in file with EE:

Additional Medical Forthcoming?

No

Comments:

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
Appeal Work Note	2/24/15	Closed	2/24/15 2:24 pm	TARA JOHNSON	CHARLAI LANG	TARA JOHNSON	2/24/15 2:24 pm

Please enter the internal work note.

Action plan review needed  
 \*\*\*\*\*  
 Agree with plan, thank you. TLJ

Correspondence - Appeals	2/9/15	Closed	2/24/15 10:57 am	CHARLAI LANG	PAVAN KUMAR	CHARLAI LANG	2/24/15 10:57 am
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Image Description: Appeal Request Form ovr dated 1/20/15 Dr. Buechel

Image Notes:

Medical Authorization Form	2/9/15	Closed	2/24/15 10:58 am	CHARLAI LANG	WEB SERVICE	CHARLAI LANG	2/24/15 10:58 am
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Please enter the Image Notes: Auth for protected health info

Medical Release Status: YES - On File

Medical Release Image #: 16830011

Date Medical Release Signed: 02/06/2015

Do you want to update the Forms tab? Yes

Correspondence - Incoming	2/9/15	Closed	2/24/15 10:58 am	CHARLAI LANG	WEB SERVICE	CHARLAI LANG	2/24/15 10:58 am
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Image Description: appeal request form

Image Notes:

Email Response to Member	2/25/15	Closed	2/25/15 5:50 pm	MARIE ANELAS	MARIE ANELAS	MARIE ANELAS	2/25/15 5:50 pm
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To Address List: **REDACTED**

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CC Address List:

Do Not Send

No

Comments:

Email From Member	2/25/15	Closed	2/25/15 5:51 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	MARIE ANELAS	2/25/15 5:51 pm
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Member Home Email Address

**REDACTED**

Date and Time Submitted

2/25/2015 1:54:00 PM

Question Category selected

My Coverage and Benefits

Question Submitted

I would like a copy of my plans Long term Disability documents please. I would like the names and contact information of any party involved with my appeal.

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action

E-mail respond to member:

PLEASE DO NOT REPLY  
This mailbox is not monitored on a daily basis.  
If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
02/25/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>  
Claim status

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Details of Response:

Response Method:

Customer Service response

Reply via email

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
Email Response to Member	2/25/15	Closed	2/25/15 7:56 am	MARIE ANELAS	MARIE ANELAS	MARIE ANELAS	2/25/15 7:56 am

To Address List: **REDACTED**

CC Address List:

Do Not Send No

Comments:

Email From Member	2/24/15	Closed	2/25/15 7:58 am	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	MARIE ANELAS	2/25/15 7:58 am
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Member Home Email Address **REDACTED**

Date and Time Submitted 2/24/2015 9:53:20 PM

Question Category selected My Appeal

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	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
------------------------------	-------------------	----------------	-------------------	-------------	------------	--------------------	----------------------

Question Submitted

On Feb 20th, I received an email response from Aetna stating "We received the Authorization to Request Protected Health Information, the Disability Appeal Request Form and your medical records for review on 02/09/2015. We will send you a confirmation letter with the details about your claim, once the review has been completed."  
I was not told anyone had reached out to me, nor did I have any voice messages from Aetna Disability, or Aetna Appeals.

Today I received a call from Charlai Lang a Senior LTD Appeals Specialist. The message did not contain her full name or direct contact information. I had to call three different departments to reach her. Ms. Lang is stating she will need an extension on my Appeals process because she tried to contact me on Jan 29th.  
I do not have a voice message from her, i save all my voice messages from the purchase date of my iPhone. I am struggling to make it and I no longer have any savings. A appeal will push me beyond Dire Straits.

I have always contacted Aetna immediately or answer my phone immediately and am very upset that my Appeal process is being delayed. My doctor has stated I cannot work, I am not working but my bills are still due each month. I wish to speak to Ms. Lang's superior because I have completed every task requested by Aetna.

View/Print 9452367 AppealAcknowledgment Letter-Incomplete 2015-01-29

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action

E-mail respond to member:

PLEASE DO NOT REPLY  
This mailbox is not monitored on a daily basis.  
If you have any questions regarding this communication, please contact Aetna at  
800-354-1779.

Dell Inc  
02/25/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in  
response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>

Claim status

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Details of Response:

Response Method:

Customer Service response

Reply via email

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Report Date: 10/06/2015



Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Internal Worknote	3/3/15	Closed	3/3/15 11:57 am	BARBARA SPEARS	BARBARA SPEARS	BARBARA SPEARS	3/3/15 11:57 am
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Please enter the internal work note.

LETTER AND PLAN MAILED TO  
ARTHUR DAVIS  
**REDACTED**  
Spring Hill, TN 37174

Appeal Extension Letter	3/4/15	Closed	3/4/15 1:54 pm	CHARLAI LANG	CHARLAI LANG	CHARLAI LANG	3/4/15 1:54 pm
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Mailing Method:

USPS

Do Not Send

No

Comments:

Appeal Employer Extension Notification	3/4/15	Closed	3/4/15 1:55 pm	CHARLAI LANG	CHARLAI LANG	CHARLAI LANG	3/4/15 1:55 pm
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To Address List:

STD\_LOA@aetna.com,SUSAN\_PARKER@DELL.COM,

CC Address List:

Do Not Send

No

Comments:

Peer Review Contact	2/3/15	Closed	3/4/15 2:01 pm	CHARLAI LANG	DANIEL BERTRAND	CHARLAI LANG	3/4/15 2:01 pm
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Last Name:

N/A

First Name:

N/A

Mid Init:

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Specialty:	Orthopedic Surgery
If Other, Please Define:	
Reason:	
Determination Due Date:	3/16/2015
First Name	Brenna
First Name	Dr. Nicholas
First Name	JAMES
First Name	Jason
First Name	SUBIR
Last Name	Green
Last Name	Cote
Last Name	RENFRO
Last Name	Knox
Last Name	PRASAD
Specialty	Physical Med & Rehab/Pain Management
Specialty	Orthopedic Surgery
Specialty	Orthopedic Surgery
Specialty	Podiatry
Specialty	Neurology
Last Office Visit	5/6/2014 12:00:00 AM
Last Office Visit	1/1/0001 12:00:00 AM
Last Office Visit	1/1/0001 12:00:00 AM

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
------------------------------	-------------------	----------------	-------------------	-------------	------------	--------------------	----------------------

Last Office Visit	1/1/0001 12:00:00 AM
Last Office Visit	5/29/2014 12:00:00 AM
Next Office Visit	6/11/2014 12:00:00 AM
Next Office Visit	1/1/0001 12:00:00 AM
Next Office Visit	4/26/2014 12:00:00 AM
Next Office Visit	1/1/0001 12:00:00 AM
Next Office Visit	1/1/0001 12:00:00 AM
Phone Number	615-867-7971
Phone Number	615-893-4480
Phone Number	615-834-4482
Phone Number	615-220-8788
Phone Number	615-425-7605
Fax Number	615-867-7974
Fax Number	615-895-6212
Fax Number	615-834-4722
Fax Number	615-220-8688
Fax Number	615-916-3953
Choose Provider:	JAMES RENFRO
Notes:	

Email Response to Member	3/4/15	Closed	3/4/15 8:36 am	SHERRI MCINNES	SHERRI MCINNES	SHERRI MCINNES	3/4/15 8:36 am
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To Address List: coachart63@gmail.com

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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CC Address List:

Do Not Send

No

Comments:

Email From Member	3/3/15	Closed	3/4/15 8:37 am	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	SHERRI MCINNES	3/4/15 8:37 am
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Member Home Email Address

**REDACTED**

Date and Time Submitted

3/3/2015 3:24:14 PM

Question Category selected

My Provider

Question Submitted

Why is Dr. Paul Buechel showing Inactive? He is my treating Nuerologist.  
Dr. Paul C. Buechel, MD, Franklin, TN, Neurology. ... Carothers Pkwy Ste 609: Franklin, TN 37067:  
(615) 550-1800 (Office): (615) 550-1801 (Fax).

Inactive Buechel, Paul (615) 550-1800

Plan of Action

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

We are able to list one healthcare provider as `Active¿ in our system. Typically, the provider listed as `Active¿ either primarily handles your disability or is the provider we have most recently contacted for medical records. Any additional provider names and contact information provided to us are kept on file and accessed when needed.

Please let us know if we can provide additional assistance.

Claim status

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Customer Service response

Details of Response:

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Response Method: Reply via email

Appeal Work Note	3/4/15	Closed	3/4/15 9:05 pm	TARA JOHNSON	CHARLAI LANG	TARA JOHNSON	3/4/15 9:05 pm
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Please enter the internal work note.

Action Plan review needed  
 \*\*\*\*\*  
 Agree with action plan, thank you. TLJ

Peer Review ARCS Assignment	3/5/15	Closed	3/5/15 9:13 am	ALICIA AGUILA	CHARLAI LANG	ALICIA AGUILA	5/28/15 9:12 am
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Peer Review Request # 99927

Peer Review Packet # of Pages: 280

Specialty: Orthopedic Surgery

If a change was made to the Specialty above, who authorized the change?

Reason why Specialty was changed:

Reviewer Assignment: 8516956

Prior Reviewers:

Peer Review PC Request	3/5/15	Closed	3/5/15 9:48 am	ROBERT CIRINCIONE, MD	ALICIA AGUILA	ROBERT CIRINCIONE, MD	3/5/15 9:48 am
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Peer Review Request #: 99927

Do you accept this Peer Review request? Yes

If no, check all that apply:

If Other was selected, provide explanation:

Additional Comments:

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Email Response to Member	3/11/15	Closed	3/11/15 8:28 pm	DOMINICA TAYLOR	DOMINICA TAYLOR	DOMINICA TAYLOR	3/11/15 8:28 pm
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To Address List:

**REDACTED**

CC Address List:

Do Not Send

No

Comments:

Email From Member	3/11/15	Closed	3/11/15 8:29 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB MOBILE	DOMINICA TAYLOR	3/11/15 8:29 pm
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Member Home Email Address

**REDACTED**

Date and Time Submitted

3/11/2015 5:09:41 PM

Question Category selected

My Appeal

Question Submitted

My surgery is scheduled for March 25th

Plan of Action

email response

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Inquiry Analysis:

Please let us know if we can provide additional assistance.

Details of Inquiry:

Claim management process

Response Analysis:

Customer Service response

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Details of Response:

Response Method: Reply via email

Email Response to Member	3/11/15	Closed	3/11/15 8:56 am	MARIE ANELAS	MARIE ANELAS	MARIE ANELAS	3/11/15 8:56 am
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To Address List: **REDACTED**

CC Address List:

Do Not Send No

Comments:

Email From Member	3/10/15	Closed	3/11/15 8:57 am	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	MARIE ANELAS	3/11/15 8:57 am
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Member Home Email Address **REDACTED**

Date and Time Submitted 3/10/2015 5:08:46 PM

Question Category selected My Appeal

Question Submitted Today I was seen by Dr. Sean Kaminsky MD, he is a Shoulder specialist at Pinnacle Surgical Partners  
5653 Frist Boulevard  
Ste 731  
Nashville, TN 37064  
615-885-2778 Fax 615-986-6052  
Dr Kaminsky confirmed the MRI findings and set recovery expectations. My right shoulder may never fully recovery and I may need shoulder replacement. I am awaiting a call from his office to set a surgery date ASAP and the expected recovery will be many months.

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
------------------------------	-------------------	----------------	-------------------	-------------	------------	--------------------	----------------------

Plan of Action

E-mail respond to member:

PLEASE DO NOT REPLY  
This mailbox is not monitored on a daily basis.  
If you have any questions regarding this communication, please contact Aetna at  
800-354-1779.

Dell Inc  
03/11/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in  
response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>

Claim status

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Details of Response:

Response Method:

Customer Service response

Reply via email

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Report Date: 10/06/2015



Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Peer Review PC Completion	3/5/15	Closed	3/15/15 10:35 am	ROBERT CIRINCIONE, MD	ROBERT CIRINCIONE, MD	ROBERT CIRINCIONE, MD	3/15/15 10:35 am
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Peer Review Request #: 99927  
I have completed the dictation. Yes

Peer Review Transcription Pending	3/16/15	Closed	3/16/15 8:47 am	ALICIA AGUILA	ROBERT CIRINCIONE, MD	ALICIA AGUILA	3/16/15 8:47 am
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Peer Review Request #: 99927  
I have received this report from the Transcription Vendor and have sent to the for review. Yes

Peer Review Clinical Approval	3/16/15	Closed	3/16/15 10:13 am	ROBERT CIRINCIONE, MD	ALICIA AGUILA	ROBERT CIRINCIONE, MD	3/16/15 10:13 am
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Peer Review Request #: 99927  
Hours: 3  
Minutes: 45  
Review Level: 3  
Physician Name: ROBERT CIRINCIONE, MD  
Date: 3/16/2015  
Hour: 10 AM  
Minute: 30  
By checking this box: Yes

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Correspondence - Appeals	3/9/15	Closed	3/17/15 4:28 pm	CHARLAI LANG	BHUPENDRA SINGH	CHARLAI LANG	3/17/15 4:28 pm
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Image Description: MRI right shoulder 03-02-15

Image Notes:

Email Response to Member	3/18/15	Closed	3/18/15 2:23 pm	MARIE ANELAS	MARIE ANELAS	MARIE ANELAS	3/18/15 2:23 pm
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To Address List:

**REDACTED**

CC Address List:

Do Not Send

No

Comments:

Email From Member	3/18/15	Closed	3/18/15 2:24 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	MARIE ANELAS	3/18/15 2:24 pm
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Member Home Email Address

**REDACTED**

Date and Time Submitted

3/18/2015 1:43:26 PM

Question Category selected

My Appeal

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Question Submitted

Good afternoon, here are the notes from my office visit with Dr. Sean Kaminsky at Pinnacle Surgical Partners in Hermitage TN.

Summary of Today's Visit

Davis , Arthur DOB: **REDACTED**

Account No 324572

Gender: Male

Race: Black or African American

Ethnicity: Not Hispanic or Latino

Preferred Language: English

03/10/2015 visit with Sean B. Kaminsky, MD

Reason for Visit

¿NP-RTSHLD

Vitals

. Ht70(in)

¿ WI 257 (lbs)

. BMI 36.87 (Index)

. Ht-cm 177.8 (cm)

. WI-kg 116.57 (kg)

Allergies

. N.KD.A.

Today's Diagnoses Include

. 719.41 Shoulder Pain, Right

. 727.61 Rotator cuff tear, nontraumatic - Right

Medication List

. Start Percocet :10-325 MG i tablet as needed Orally every 6 hls,50

Other medications you are on

. Celebrex:

. Cymbalta :

. Tramadol HC1 :

Notes:

I reviewed the results of the MRI study of the right shoulder from March 2, 2015 revealing a massive tear of the supraspinatus and infraspinatus tendons with retraction of approximately 5 cm and muscular atrophy.

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Subscapularis tenosynovitis present. Subacromial and glenohumeral fluid noted. Biceps tear and synovitis present.

, I reviewed the findings and options for treatment such as medication, injections, living with the symptoms.

activity modification, more time, and finally surgery. Patient did not feel that conservative treatment is worked for him at all. I also discussed various options for surgery including arthroscopic surgery, latissimus transfer

surgeon, and shoulder arthroplasty. We discussed each of these options and return any feels that shoulder arthroscopy would be his best option. However, I discussed what arthroscopic surgery entails including the lengthy recovery and rehabilitation, time out of work or activity, limited use of the arm, and need for post operative physical therapy. I have reviewed where the portal site and incisions would be potentially placed and how the procedure is performed. We discussed sleeping in a recliner chair or propped up in bed. ice on the shoulder, and the use of pain medication postoperatively. Risks of surgery were discussed including but not limited to bleeding, infection, nerve, vein, or artery injury, continuing pain, risks of anesthesia including loss of life or limb, heart attack, blood clot, seizure, stroke, failure of any surgery, need for further surgery, and stiffness.

After having this discussion, the patient wants to proceed with surgery. We have completed the paperwork.

answered all questions, provided prescriptions for medication to use post-operatively, my card, anti information for the surgery center. I encouraged the patient to call me with any questions or concerns about our discussions

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action

E-mail respond to member:

PLEASE DO NOT REPLY  
This mailbox is not monitored on a daily basis.  
If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
03/18/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>

Claim status

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Details of Response:

Response Method:

Customer Service response

Reply via email

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Peer Review	3/20/15	Closed	3/20/15 8:16 pm	SHAWNDR LEE	DASHRAT SINGHBIST	DASHRAT SINGHBIST	3/20/15 8:16 pm
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Image Description: Peer Review.

Image Notes:

Email Response to Member	3/23/15	Closed	3/21/15 6:55 pm	SHERRI MCINNES	SHERRI MCINNES	SHERRI MCINNES	3/23/15 8:06 am
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To Address List:

**REDACTED**

CC Address List:

Do Not Send

No

Comments:

Email From Member	3/20/15	Closed	3/21/15 6:56 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	SHERRI MCINNES	3/23/15 8:06 am
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Member Home Email Address

**REDACTED**

Date and Time Submitted

3/20/2015 9:33:43 PM

Question Category selected

My Appeal

Question Submitted

I would like to request a copy of my Aetna Disability file please. Do I have to submit this in writing?

Plan of Action

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your request for a copy of your disability file has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Inquiry Analysis:

Claim status

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Details of Inquiry:

Response Analysis: Referred to claim owner

Details of Response:

Response Method: Reply via email

Correspondence - Appeals	4/3/15	Closed	4/13/15 6:26 pm	CHARLAI LANG	KAPIL SINGH	CHARLAI LANG	4/13/15 6:26 pm
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Image Description: PT note from Dr. Kaminsky 3/31/15 OP Report dated 3/25/15

Image Notes:

Correspondence - Incoming	4/9/15	Closed	4/13/15 6:27 pm	CHARLAI LANG	JASEEM ANSARI	CHARLAI LANG	4/13/15 6:27 pm
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Image Description: request for copy of records from EE

Image Notes:

Appeal Plan of Action	2/3/15	Closed	4/13/15 6:37 pm	CHARLAI LANG	DANIEL BERTRAND	CHARLAI LANG	4/13/15 6:37 pm
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Plan Name	DD
ERISA	Yes
Funding Type	Insured
Appeal ID	11345031
Level of Appeal	
Final Fiduciary	
Reason for Claim Denial/Termination	Disability Not Supported

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Job Title	INSIDE SALES ACCOUNT MGMT III
Is job description in file?	Yes
Date Requested	
First Day Absent	10/9/2013 12:00:00 AM
Benefit Begin Date	4/7/2014 12:00:00 AM
Approved Start Date	4/7/2014 12:00:00 AM
Approved Thru Date	1/11/2015 12:00:00 AM
Date Benefit Denied/Terminated	

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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#### Comments

EE is a 51 year old male inside sales account manager who went oow effective 10-09-13 due to left massive rotator cuff tear and bicep tendon attrition. EE had repair on 10-11-13 and was advised out of work through 1-14-14 with post-surgical tx of physical therapy and pain medication. Medical support through 1-15-15 and ee was found to have sedentary work capacity.

Medical info  
MRI dated 10-01-13 of left shoulder revealed a large joint effusion with an 8x8x4 chondral loose body within the subscapularies recess. EE revealed in 10-07-13 ee has a long standing history of discomfort int eh shoulders related to different activities. EE most recently jerked to lawnmower and experienced significant increase in discomfort of his left shoulder with the inability to raise his arm, pain level was a 10 out of 10 since then. EE also had significant discomfort in the right shoulder but it is functional. EE also had a recent MVA where he was rear ended in has upper back discomfort. EE had slow progress with therapy by 11-15-13 and was still unable to lift his left arm, no change with pain level. December 13, 2013 ee is two months status post-surgery and has been doing passive and assisted exercises with therapy. EE continues with discomfort. EE followed up on 1-28-14 with a new problem involving his left knee. Ee was sitting down with his legs crossed and went to stand up and had immediate pain in the medial compartment and his knee locked, ee was already scheduled for rotator cuff surgery in three days. EE had right shoulder rotator cuff tear with chronic impingement completed on 1-31-14. Ee also had to work on pendulum exercise and passive motion exercises. The 2-18-14 PT note confirmed ee can reach behind his back with more ROM that the previous week, ee reports weakness and overhead activities still diff. ee still has tightness In all planes but improved. Ovn dated 3-11-14 ee was six weeks postop his left knee meniscal tear and would like to schedule his left knee surgery. Plan was to continue light strengthening program with shoulder. EE had left knee surgery on 4-18-14. EE functionality began to be evaluated and it was suggested ee have a FCE to determine abilities and restrictions. HCP in August 2014 determined that ee's symptoms of feet pan and burning could be due to back pain and physical therapy and ee was to see a back surgeon. EE had MRI Lumbar dated 11-6-14 which revealed scattered lumbar degenerative and stenotic findings as detailed in the body of the report without more than mild stenosis at any level, incomplete image degenerative findings in lower thoracic spine with probable associated at T10-T11 asymmetric toward the right. As a result of continued back pain and numbness symptoms PT was ordered. The 1-20-15 ovn indicates ee is unable to perform his duties and will see a neurosurgeon for his back. Medications(grailise titrate prn) has reportedly made ee groggy.

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action	A/S to confirm with ee if additional information is forthcoming other than the ovr from 1-20-15. A/S questions if ee saw a neurosurgeon regarding continued back pain
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Peer Review Analysis	3/20/15	Closed	4/13/15 6:44 pm	CHARLAI LANG	DASHRAT SINGHBIST	CHARLAI LANG	4/13/15 6:44 pm
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First Name	Robert
Last Name	Cirincione
Mid Init	
Speciality	Orthopedic Surgery
Vendor Name	AETNA
Peer to Peer Contact	Successful in contacting the Treating Provider
Referral Completion Date	03/05/2015
Outcome	Fails to support functional Impairment for the entire timeframe
Appeal Related?	Yes
Level	1
Date Completed by Physician	03/15/2015
Date Received	03/16/2015
Additional Notes	
Additional Notes (con't)	
Plan of Action	Uphold decision as medical does not support the inability to perform a sedentary work capacity

Peer Review Completion Notification	3/16/15	Closed	4/13/15 6:48 pm	CHARLAI LANG	ROBERT CIRINCIONE, MD	CHARLAI LANG	4/13/15 6:48 pm
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Peer Review Request #	99927
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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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The completed peer report is received and is attached to the review from the peer review workspace screen. Yes

Appeal Determination	4/22/15	Closed	4/13/15 7:10 pm	CHARLAI LANG	DANIEL BERTRAND	CHARLAI LANG	4/13/15 7:10 pm
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Plan Name	DD
ERISA	Yes
Funding Type	Insured
Appeal ID	11345031
Level of Appeal	
Final Fiduciary	Aetna
Reason for Claim Denial/Termination	Disability Not Supported
Job Title	INSIDE SALES ACCOUNT MGMT III
First Day Absent	10/9/2013 12:00:00 AM
Benefit Begin Date	4/7/2014 12:00:00 AM
Approved Start Date	4/7/2014 12:00:00 AM
Approved Thru Date	1/11/2015 12:00:00 AM
Date Benefit Denied/Terminated	1/12/2015 12:00:00 AM
Appeal Decision	Upheld
Decision Reason	Disability not supported
Authorized From:	
Authorized Thru	

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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#### Decision Rationale

EE is a 51 year old male inside sales account manager who went oow effective 10-09-13 due to left massive rotator cuff tear and bicep tendon attrition. EE had repair on 10-11-13. Claim was approved through 1-15-15.

Peer review was completed along with consults with ee's providers

Peer reviewer opined medical supports a functional impairment involving the claimant's bilateral upper extremities which includes a repaired right rotator cuff and a recurrent massive left rotator cuff tendon rupture. The left rotator cuff tear is not reparable. These findings support a functional impairment in both upper extremities which would support the claimant being unable to lift greater than five pounds or do any lifting above shoulder height. The claimant should be restricted to work below shoulder height and limit lifting, pushing, pulling to five pounds or less with both upper extremities. Therefore from this standpoint ee would have been able to work as ee is not required to lift and work overhead.

EE back pain is not supported by the medical exam findings nor the diagnostic testing to prevent sedentary work capacity. The majority of the medical exam findings were wnl, EE was given a dx of causalgia however objective findings including coolness of extremity, hypersensitivity to touch, edema, loos of active motion as well as hair and nail changes. therefore causalgia is not supported beause this dx is given when there is abnormal response to pain and stimulus

#### Additional Decision Rationale

Decision By

Appeal Coordinator

Comments

Email Response to Member	4/13/15	Closed	4/13/15 7:53 am	DOMINICA TAYLOR	DOMINICA TAYLOR	DOMINICA TAYLOR	4/13/15 7:53 am
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To Address List:

**REDACTED**

CC Address List:

Do Not Send

No

Comments:

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Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Email From Member	4/13/15	Closed	4/13/15 7:54 am	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	DOMINICA TAYLOR	4/13/15 7:54 am
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Member Home Email Address	<b>REDACTED</b>
Date and Time Submitted	4/12/2015 7:34:56 AM
Question Category selected	My Appeal
Question Submitted	Good morning, I faxed a request for my file but did not receive an acknowledgment. Has Aetna received my fax request?
Plan of Action	email response
	Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.
	Your request for a copy of your claim file was forwarded to your Claim Manager.
	Please let us know if we can provide additional assistance.
	Claim management process
	Customer Service response
	Reply via email

Correspondence - Incoming	4/13/15	Closed	4/16/15 4:17 pm	CHARLAI LANG	PAVAN KUMAR	CHARLAI LANG	4/16/15 4:17 pm
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Image Description:	requesting copy of his file
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Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Image Notes:

Email Response to Member	4/20/15	Closed	4/18/15 9:35 am	SHERRI MCINNES	SHERRI MCINNES	SHERRI MCINNES	4/18/15 9:35 am
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To Address List: **REDACTED**

CC Address List:

Do Not Send: No

Comments:

Email From Member	4/17/15	Closed	4/18/15 9:36 am	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	SHERRI MCINNES	4/18/15 9:36 am
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Member Home Email Address: **REDACTED**

Date and Time Submitted: 4/17/2015 4:58:36 PM

Question Category selected: My Appeal

Question Submitted: Good afternoon today I dropped off updated paperwork to the Social security administration. Looking at my timeline, my LTD was approved through Aetna for my shoulder issues. I was out on under doctors care until May 23rd 2014 specifically for my shoulders. Looking at notes from Physical Therapy I was complaining about my shoulders up to the release date. I complained to my surgeon that I was hearing popping and clicking noises but was told it would go away as my shoulders strengthen. 5 months later I was back to his office and two months after I was scheduled for another reattachment. It does not appear that my shoulders healed properly and based on my new surgeons findings, my right shoulder may not return to normal. My left shoulder is still popping and I have occasional pain and I will probably have to have additional surgery on it. How can I be removed from LTD if I never healed? I have been told I cannot work because of my back and the situation is magnified by my shoulder issues.

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Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Appeal Specialist.

Please let us know if we can provide additional assistance.

Claim status

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Referred to claim owner

Details of Response:

Response Method:

Reply via email

Email Response to Member	4/20/15	Closed	4/20/15 6:19 pm	MARIE ANELAS	MARIE ANELAS	MARIE ANELAS	4/21/15 8:46 am
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To Address List:

**REDACTED**

CC Address List:

Do Not Send

No

Comments:

Email From Member	4/20/15	Closed	4/20/15 6:19 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	MARIE ANELAS	4/21/15 8:46 am
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Member Home Email Address

**REDACTED**

Date and Time Submitted

4/20/2015 1:42:09 PM

Question Category selected

My Appeal

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Question Submitted

I submitted a request via Document Download. I am submitted here also.

Appeal Status	Appeal Decision	Due Date
Active	Upheld	04/22/2015

Good morning Charlai, I see the decision has been made concerning my appeal. Are there any additional  
Appeal options? If I do not have any appeal options please send me the Denial letter and my Aetna records thank you.

Arthur Cyril Davis Jr.

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Report Date: 10/06/2015



Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action

E-mail respond to member:

PLEASE DO NOT REPLY  
This mailbox is not monitored on a daily basis.  
If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
04/20/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your e-mail has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>  
Claim status

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Details of Response:

Response Method:

Customer Service response

Reply via email

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Appeal Work Note	4/20/15	Closed	4/23/15 4:20 pm	DONNA KIRKBY	CHARLAI LANG	DONNA KIRKBY	4/23/15 4:20 pm
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Please enter the internal work note.

Uphold ltr review needed Decision due 4-13-15

Email Response to Member	4/23/15	Closed	4/23/15 5:02 pm	MARIE ANELAS	MARIE ANELAS	MARIE ANELAS	4/24/15 8:15 am
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To Address List:

**REDACTED**

CC Address List:

Do Not Send

No

Comments:

Email From Member	4/23/15	Closed	4/23/15 5:03 pm	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB MOBILE	MARIE ANELAS	4/24/15 8:15 am
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Member Home Email Address

**REDACTED**

Date and Time Submitted

4/23/2015 10:19:01 AM

Question Category selected

My Appeal

Question Submitted

Good morning I spoke to me claims manager this week and was told I would get a decision letter on the 22nd. I do not see a generated letter?

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Plan of Action

E-mail respond to member:

PLEASE DO NOT REPLY  
This mailbox is not monitored on a daily basis.  
If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
04/23/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager along with a request to call you.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>  
Claim status

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Details of Response:

Response Method:

Customer Service response

Reply via email

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Appeal Work Note	4/23/15	Closed	4/24/15 11:20 am	CHARLAI LANG	DONNA KIRKBY	CHARLAI LANG	4/24/15 11:20 am
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Please enter the internal work note. Manager reviewed case and agree with determination - DLK

Appeal - Partial Overturn or Upheld Letter	4/13/15	Closed	4/24/15 11:28 am	CHARLAI LANG	CHARLAI LANG	CHARLAI LANG	4/24/15 11:28 am
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Do Not Send No

Comments:

Free Form Letter STD-LTD	4/24/15	Closed	4/24/15 12:04 pm	CHARLAI LANG	CHARLAI LANG	CHARLAI LANG	4/24/15 12:04 pm
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Mailing Method: USPS

Do Not Send Yes

Comments:

Appeal Determination ER Contact Email	4/13/15	Closed	4/24/15 12:06 pm	CHARLAI LANG	CHARLAI LANG	CHARLAI LANG	4/24/15 12:06 pm
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To Address List: STD\_LOA@aetna.com,SUSAN\_PARKER@DELL.COM,

CC Address List:

Do Not Send No

Comments:

Internal Worknote	4/28/15	Closed	4/28/15 10:46 am	BARBARA SPEARS	BARBARA SPEARS	BARBARA SPEARS	4/28/15 10:46 am
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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Please enter the internal work note.

PREPARED CLAIM FILES 8893435 AND 9452367 TO CD AND FIRST REVEIW COMPLETED  
GAVE CD TO ROBYN FOR SECOND REVEIW. COPY MADE.

Email From Member	4/29/15	Closed	4/29/15 6:01 pm	NA REGIONAL CALL CENTER	WKAB SYSTEM	DOMINICA TAYLOR	4/29/15 6:01 pm
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EMAIL QUEUE USER 1

Member Home Email Address

**REDACTED**

Date and Time Submitted

4/29/2015 12:05:41 PM

Question Category selected

My Appeal

Question Submitted

On April 24, 2015 I spoke with Charlai Lang  
Disability Appeals Specialist. I was assured a Decision Letter would be mailed along with my  
Aetna file. I have not received anything as of today.

Plan of Action

email response

Thank you for using the secure member website to contact Aetna Disability. This is in  
response to your email concerning Claim #: 8893435.

The claim file is enroute to you via UPS. The tracking number is 1Z1E75E30298645260. It is  
guaranteed to be delivered to you by the end of the day of 04/30/2015.

Please let us know if we can provide additional assistance.

Forms

Inquiry Analysis:

Details of Inquiry:

Response Analysis:

Customer Service response

Details of Response:

Response Method:

Reply via email

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Internal Worknote	5/1/15	Closed	5/1/15 9:25 am	BARBARA SPEARS	BARBARA SPEARS	BARBARA SPEARS	5/1/15 9:25 am
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Please enter the internal work note.

PASSWORD EMAIL FOR CLAIMS 9452367 AND 8893435  
 From: Art [mailto:**REDACTED**]  
 Sent: Thursday, April 30, 2015 5:21 PM  
 To: Mailme  
 Subject: Claim 9452367

REPLIED WITH PASSWORD

Email Response to Member	5/7/15	Closed	5/7/15 11:33 am	THEODORA WILLIAMS	THEODORA WILLIAMS	THEODORA WILLIAMS	5/7/15 11:33 am
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To Address List:

**REDACTED**

CC Address List:

Do Not Send

No

Comments:

Email From Member	5/6/15	Closed	5/7/15 11:33 am	NA REGIONAL CALL CENTER EMAIL QUEUE USER 1	WKAB SYSTEM	THEODORA WILLIAMS	5/7/15 11:33 am
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Member Home Email Address

**REDACTED**

Date and Time Submitted

5/6/2015 4:16:32 PM

Question Category selected

My Appeal

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Question Submitted

Good afternoon. On 4/28/2015, Aetna received information regarding my claim. Has there been a decision to reopen my claim?

Plan of Action

Aetna received information regarding your claim. We are currently reviewing the updates and will be in contact with you if we have any questions. You can always obtain the most recent status on your claim by accessing our WorkAbility home page.

email response to member

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

We received a letter of representation and appeal request from Cody Allison and Associates on 04/28/2015. This information was forwarded to your Appeal Specialist for review.

Inquiry Analysis:

Please let us know if we can provide additional assistance.

Details of Inquiry:

Was Paperwork received

Response Analysis:

Customer Service response

Details of Response:

Response Method:

Reply via email

Correspondence - Outgoing	4/28/15	Closed	5/26/15	8:45 am	CHARLAI LANG	ASHUTOSH NARAYAN SINGH	CHARLAI LANG	5/26/15	8:45 am
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Image Description:

UPS Label request for copy of file

Image Notes:

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Correspondence - Appeals	4/28/15	Closed	5/26/15 8:47 am	CHARLAI LANG	JASEEM ANSARI	CHARLAI LANG	5/26/15 8:47 am
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Image Description: Ltr from Atty requesting a re open of appeal

Image Notes:

Correspondence - Appeals	4/28/15	Closed	5/26/15 8:51 am	CHARLAI LANG	JASEEM ANSARI	CHARLAI LANG	5/26/15 8:51 am
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Image Description: request for copy of file from atty

Image Notes:

Correspondence - Appeals	4/30/15	Closed	5/28/15 9:27 am	CHARLAI LANG	RAJESH KUMAR	CHARLAI LANG	5/28/15 9:27 am
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Image Description: atty request for copy of the file and policy

Image Notes:

Correspondence - Appeals	5/27/15	Closed	5/28/15 9:31 am	NA APPEAL QUEUE USER 1	NAVTEJ BHADUR	CHARLAI LANG	5/28/15 9:31 am
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Image Description: ltr from atty requesting copy of the file

Image Notes:

Free Form Letter STD-LTD	5/28/15	Closed	5/28/15 11:22 am	CHARLAI LANG	CHARLAI LANG	CHARLAI LANG	5/28/15 11:22 am
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Mailing Method: USPS

Do Not Send: Yes

Comments:

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Report Date: 10/06/2015



Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Internal Worknote	5/29/15	Closed	5/29/15 9:12 am	STEPHEN DEKUBBER	STEPHEN DEKUBBER	STEPHEN DEKUBBER	5/29/15 9:12 am
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Please enter the internal work note.

Please include all wkb notes, CNS notes, medical file, SIU links, letters and policy  
Charlai Lang  
LTD Appeals Specialist  
Cover Letter Included. Completed awaiting 2nd review will add ups tracking once review is  
competed.

Internal Worknote	5/29/15	Closed	5/29/15 10:59 am	STEPHEN DEKUBBER	STEPHEN DEKUBBER	STEPHEN DEKUBBER	5/29/15 10:59 am
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Please enter the internal work note.

SHIP TO:  
Cody Allison & Associates  
ATTN: K CODY ALLISON  
501 UNION ST. STE:502  
NASHVILLE, TN 37217

Tracking Number: 1Z1E75E30290327387 Service: UPS 2nd Day AirGuaranteed By: End of Day  
Tuesday, Jun 2, 2015

Correspondence - Incoming	5/29/15	Closed	6/1/15 10:09 am	SHAWNDR A LEE	ANKESH KUMAR	SHAWNDR A LEE	6/1/15 10:09 am
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Image Description:

Correspondence - Incoming

Image Notes:

Correspondence - outgoing

Internal Worknote	9/17/15	Closed	9/17/15 7:44 am	BARBARA SPEARS	BARBARA SPEARS	BARBARA SPEARS	9/17/15 7:44 am
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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Please enter the internal work note.

PASSWORD EMAIL  
 From: rick@codyallison.com [mailto:rick@codyallison.com]  
 Sent: Wednesday, September 16, 2015 5:49 PM  
 To: Mailme  
 Subject: Claim No.: 9452367 -- Our Client Arthur Davis  
 Importance: High

Dear Sir or Madam:

Please provide me with the pass word to open the CD that you provided to my office.

If you have any questions, you can reach me at the number listed below or email me back.

Your cooperation to this matter is appreciated.

Thank you.

Rick Adkins, Legal Assistant  
 Cody Allison & Associates, PLLC  
 501 Union Street, Suite 502  
 Nashville, TN 37219  
 T: (615) 234-6000  
 F: (615) 727-0175  
 rick@codyallison.com

REPLIED WITH PASSWORD

Correspondence - Appeals	6/1/15	Closed	10/2/15 2:08 pm	CHARLAI LANG	RAJESH KUMAR	DANIEL BERTRAND	10/2/15 2:08 pm
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Image Description:

APPEAL

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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Image Notes:

Attorney Contact	10/5/15	Closed	10/5/15 12:53 pm	KELLY WIERS	KELLY WIERS	KELLY WIERS	10/5/15 12:53 pm
------------------	---------	--------	------------------	-------------	-------------	-------------	------------------

Contact Reason:	Notification
Attorney Representation:	Yes
Litigation Status	Active-No EE Contact
Notes	Special Handling- Lawsuit Filed.
Plan of Action:	BES to file.
Contact Outcome:	Completed

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

<b>Task Name &amp; Task Details:</b>	<b>Scheduled Date</b>	<b>Task Status</b>	<b>Completed Date</b>	<b>Claim Owner</b>	<b>Originator</b>	<b>Last Updated By</b>	<b>Date Last Updated</b>
--	---------------------------	------------------------	---------------------------	--------------------	-------------------	----------------------------	------------------------------

### Notes Trending by Claim Status

	Total	Closed
<b>Total</b>	273	273
Email From Member	35	35
Email Response to Member	34	34
Analysis/Review Medical Records	28	28
Correspondence - Incoming	22	22
Fax Form Confirmation Task	14	14
Faxed Form Request	14	14
Correspondence - Appeals	10	10
Internal Worknote	8	8
Follow Up SSDI Review Task	7	7
Mail Provider Forms	7	7
Free Form Letter STD-LTD	6	6
Financial Worknote	5	5
Appeal Work Note	4	4

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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	Total	Closed
Clinical Review Acknowledgement	4	4
Employer Contact Email	4	4
Medical Authorization Form	4	4
Claim Owner Reassignment	3	3
LTD Claimant Interview	3	3
LTD Follow Up Clinical Review	3	3
Correspondence - Outgoing	2	2
LTD Determination EE Contact	2	2
LTD Disability Determination	2	2
Tax Forms	2	2
Appeal - Partial Overturn or Upheld Letter	1	1
Appeal Determination	1	1
Appeal Determination ER Contact Email	1	1
Appeal Employer Extension Notification	1	1
Appeal Extension Letter	1	1

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Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
------------------------------	-------------------	----------------	-------------------	-------------	------------	--------------------	----------------------

	Total	Closed
Appeal Follow Up for Triage	1	1
Appeal Plan of Action	1	1
Other Notes which are not in the Above Categories	43	43

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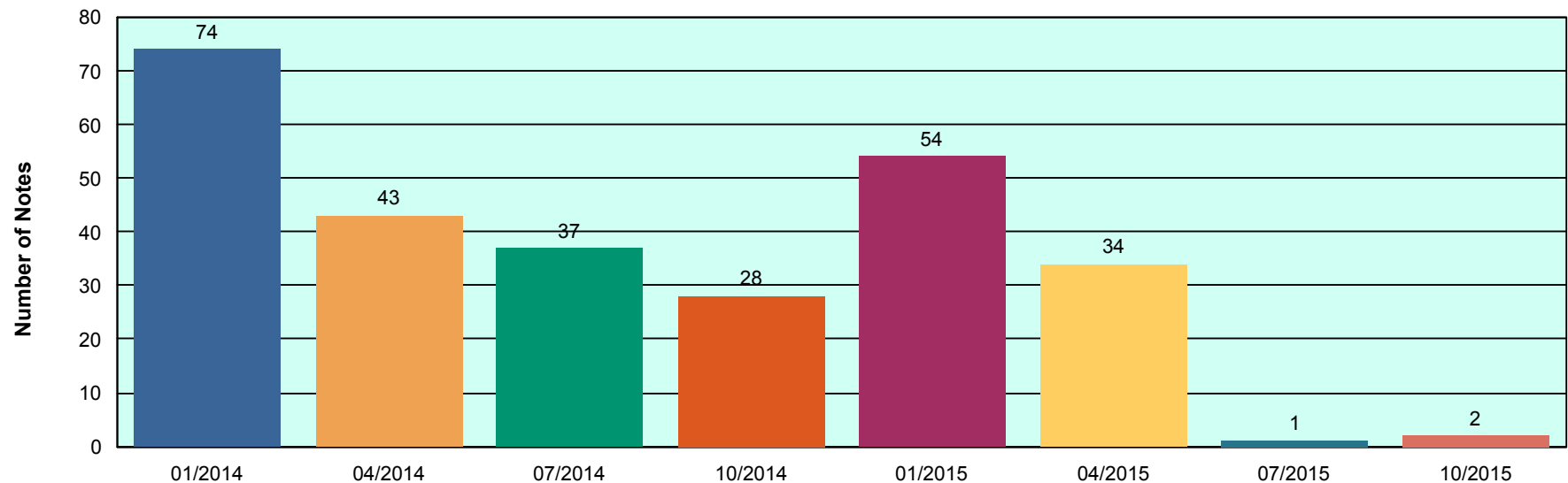
Report Date: 10/06/2015

Client Name: <b>Dell Inc</b>	Last Name: <b>DAVIS</b>	First Name: <b>ARTHUR</b>	Middle Initial: <b>C</b>
	Employee ID: <b>157406572</b>	Date of Birth: <b>REDACTED</b>	Age: <b>52</b>
Work State: <b>TN</b>	Claim ID: <b>9452367</b>	Date of Hire: <b>05/22/2006</b>	Gender : <b>M</b>
Preferred Contact: <b>REDACTED</b> Phone (Mobile)			

Task Name & Task Details:	Scheduled Date	Task Status	Completed Date	Claim Owner	Originator	Last Updated By	Date Last Updated
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### Note Summary

Number of Notes Updated by Date (By Quarter)



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Report Date: 10/06/2015

(Less Info)

Client Name: Dell Inc

Claim Status: Closed

Date of Birth: REDACTED

Contract Situs: TX

Preferred Contact#: REDACTED

Work Capacity Level: No Current Work Capacity

Claim Owner: LEE, SHAWNDR

Age: 52

Tier: Tier 3

Phone (Mobile) End Of Benefit(EOB): 10/31/2028

IHD Consent Effective: N/A

OP Balance: N/A

Gender: Male

Estimated RTW:

Disability Date: 10/09/2013

Age at DCI: 50

Current Analytics:

6 Month Duration

3

12 Month Duration

4

18 Month Duration

5

24+ Month Duration

7

Providers

Benefit Engine

PeopleSoft

Rehab Vendors

Alerts	Contacts	Summary & Action Plan	Medical	Vocational	Financial
Active Member Alerts					
Submit Action					
Create Date	Claim ID	Alert Name	Notification	Created By	Action
▼ 06/01/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	RAJESH KUMAR	Please Select ▼
▼ 05/29/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	ANKESH KUMAR	Please Select ▼
▼ 05/27/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	NAVTEJ BHADUR	Please Select ▼
▼ 04/28/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	JASEEM ANSARI	Please Select ▼
▼ 04/28/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	JASEEM ANSARI	Please Select ▼
▼ 02/09/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	PAVAN KUMAR	Please Select ▼
▼ 01/14/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	BHUPENDRA SINGH	Please Select ▼
▼ 01/08/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	ARUN CHAWLA	Please Select ▼
▼ 12/26/2014	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	ROHIT SINGH	Please Select ▼
▼ 09/29/2014	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	YADAV VIKAS	Please Select ▼

Alerts And Notification History

Expand All Details

View

All

Show 10 Notes

<< < 1 2 3 4 5 of 5 > >>

Create Date	Claim ID	Alert Name	Notification (Y/N)	Created By	Dismiss Date
▼ 04/30/2015	9452367	Aetna received information regarding your claim	Not Being Sent	RAJESH KUMAR	05/03/2015
▼ 04/03/2015	9452367	Aetna received information regarding your claim	Not Being Sent	KAPIL SINGH	04/18/2015
▼ 03/20/2015	9452367	Aetna received information regarding your claim	Not Being Sent	DASHRAT SINGHBIST	04/18/2015
▼ 03/09/2015	9452367	Aetna received information regarding your claim	Not Being Sent	BHUPENDRA SINGH	03/15/2015
▼ 02/09/2015	9452367	Aetna received information regarding your claim	Not Being Sent	WEB SERVICE	02/17/2015
▼ 02/09/2015	9452367	Aetna received information regarding your claim	Not Being Sent	WEB SERVICE	02/17/2015



▼ 01/30/2015	9452367	Authorization to Request Health Information	Not Being Sent	CANDICE HOY	02/09/2015
▼ 01/30/2015	9452367	Disability Appeal Request Form	Not Being Sent	CANDICE HOY	02/09/2015
▼ 01/29/2015	9452367	Aetna received information regarding your claim	Not Being Sent	YADAV VIKAS	02/17/2015
▼ 01/13/2015	9452367	Aetna has issued a payment	Not Being Sent	WKAB SYSTEM	02/17/2015

Client Name: Dell Inc

Claim Status: Closed

Date of Birth: REDACTED

Contract Situs: TX

Preferred Contact#: REDACTED

Current Analytics:

Work Capacity Level: No Current Work Capacity

Claim Owner: LEE, SHAWNDR

Age: 52

Tier: Tier 3

Phone (Mobile) End Of Benefit(EOB): 10/31/2028

6 Month Duration 3 12 Month Duration 4 18 Month Duration 5 24+ Month Duration 7

(Less Info)

IHD Consent Effective: N/A

OP Balance: N/A

Gender: Male

Estimated RTW:

Disability Date: 10/09/2013

Providers

Benefit Engine

PeopleSoft

Rehab Vendors

Age at DCI: 50

Alerts

Contacts

Summary & Action Plan

Medical

Vocational

Financial

▲ Manage Notes: ADD NEW

Subject	Create Date	Creator	Title	Claim #	Contact
* Claim Status	10/6/2015 5:08:10 AM	PRAKASH PRASAD	PARALEGAL II	9452367 (LTD) Closed	* Employee

Topic:\*

Save

See Reminders

Cancel

< >

▲ Follow Up Required

Task Name	Schedule Date	Assign Owner	Memo
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<input type="checkbox"/> Action Required	10/06/2015		LEE,SHAWNDR	Select	
<input type="checkbox"/> Complaint Follow Up Required	10/06/2015		LEE,SHAWNDR	Select	
<input type="checkbox"/> Email Provider Forms	10/06/2015		LEE,SHAWNDR	Select	
<input type="checkbox"/> Email Supplemental Forms	10/06/2015		LEE,SHAWNDR	Select	
<input type="checkbox"/> Employee Contact	10/06/2015		LEE,SHAWNDR	Select	
<input type="checkbox"/> Employer Contact	10/06/2015		LEE,SHAWNDR	Select	
<input type="checkbox"/> Faxed Form Request	10/06/2015		LEE,SHAWNDR	Select	

Save & Create task

Contact Notes History

Expand All Details

View Claim : 9452367

Contact Filter All

Subject Filter All

Show 10

Notes

<< < 1 2 3 4 5 of 9 > >>

Subject	Last Update Date	Creator	Title	Claim #	Contact
▼ Appeal	5/28/2015 9:26:22 AM	CHARLAI LANG	Disability Appeals Specialist	9452367 (LTD) Closed	Other
Topic: outgoing call to Atty office					
▼ Claim Status	5/27/2015 11:57:01 AM	PATRICIA HICKEY	Customer Svc Representative	9452367 (LTD) Closed	Other
Topic: speak to appeals analyst					
▼ Appeal	4/24/2015 11:50:48 AM	CHARLAI LANG	Disability Appeals Specialist	9452367 (LTD) Closed	Employee
Topic: outgoing call to ee returning call					
▼ E-mail from Member	4/23/2015 5:01:48 PM	MARIE ANELAS	Customer Svc Representative	9452367 (LTD) Closed	Employee
Topic: e-mail from member-					
▼ E-mail from Member	4/20/2015 6:17:19 PM	MARIE ANELAS	Customer Svc Representative	9452367 (LTD) Closed	Employee
Topic: e-mail from member.					
▼ Appeal	4/20/2015 5:56:34 PM	CHARLAI LANG	Disability Appeals Specialist	9452367 (LTD) Closed	Employee
Topic: call returned					
▼ Appeal	4/20/2015 5:55:09 PM	CHARLAI LANG	Disability Appeals Specialist	9452367 (LTD) Closed	Employee
Topic: outgoing call to ee returning call					
▼ E-mail from Member	4/18/2015 9:34:29 AM	SHERRI MCINNES	Customer Service Rep	9452367 (LTD) Closed	Employee
Topic: update on claim					
▼ Appeal	4/16/2015 4:20:29 PM	CHARLAI LANG	Disability Appeals Specialist	9452367 (LTD) Closed	Employee
Topic: outgoing call to ee returning call					
▼ Claim Status	4/16/2015 1:10:36 PM	SANDRA QUELLA	Customer Svc Representative	9452367 (LTD) Closed	Employee
Topic: TCF EE To check on the status of the claim					

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : CLAIM

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
---------	------------------	---------	-------	---------	--------

Topic: outgoing call to Atty office  
spoke with Nikki to leave msg for atty, on A/S vm the atty was requesting re open of the appeal and a copy of the file, Atty indicated that she just got on board to represent ee and A/S advised the file is already closed. The decision ltr went out on 4/23/15 and ee had already requested a copy of the filed on 4/13/15. the Atty does have the option to file suit but we can't open the case again and give more time after it's been closed

Claim Status	05/27/2015 11:57:01AM	PATRICIA HICKEY	Customer Srvc Representative	9452367	Other
--------------	-----------------------	-----------------	------------------------------	---------	-------

Topic: speak to appeals analyst  
Barbara atty for EE asked to speak to appeals analyst. She was unavailable. Xfrd to vm

authorization form date 4/30 image 17415744

Barbara 615 234 6000  
Cody Allison

Appeal	04/24/2015 11:50:48AM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
--------	-----------------------	--------------	-------------------------------	---------	----------

Topic: outgoing call to ee returning call  
A/S advised that unfortunately the medical documentation did not support ongoing impairment and ltr was mailed today, ee stated he just want a copy of his file with direction on how to file suit. A/S advised that ee would need to take file to any atty who will give ee direction on how to file suit ee thanked A/S

E-mail from Member	04/23/2015 5:01:48PM	MARIE ANELAS	Customer Srvc Representative	9452367	Employee
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Topic: e-mail from member-  
Good morning I spoke to me claims manager this week and was told I would get a decision letter on the 22nd. I do not see a generated letter?

E-mail from Member	04/20/2015 6:17:19PM	MARIE ANELAS	Customer Srvc Representative	9452367	Employee
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Topic: e-mail from member.  
I submitted a request via Document Download. I am submitted here also.  
Appeal Status Appeal Decision Due Date  
Active Upheld 04/22/2015  
Good morning Charlai, I see the decision has been made concerning my appeal. Are there any additional  
Appeal options? If I do not have any appeal options please send me the Denial letter and my Aetna records thank you.  
Arthur Cyril Davis Jr.

Appeal	04/20/2015 5:56:34PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: call returned  
file will be released after decision is finalized

Appeal	04/20/2015 5:55:09PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
--------	----------------------	--------------	-------------------------------	---------	----------

Topic: outgoing call to ee returning call  
To advise that the decision ltr is under review and A/S will release a copy of the medical file once the ltr is released ee thanked A/S

E-mail from Member	04/18/2015 9:34:29AM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
--------------------	----------------------	----------------	----------------------	---------	----------

Topic: update on claim  
Good afternoon today I dropped off updated paperwork to the Social security administration. Looking at my timeline, my LTD was approved through Aetna for my shoulder issues. I was out on under doctors care until May 23rd 2014 specifically for my shoulders. Looking at notes from Physical Therapy I was complaining about my shoulders up to the release date. I complained to my surgeon that I was hearing popping and clicking noises but was told it would go away as my shoulders strengthen. 5 months later I was back to his office and two months after I was scheduled for another reattachment. It does not appear that my shoulders healed properly and based on my new surgeons findings, my right shoulder may not return to normal. My left shoulder is still popping and I have occasional pain and I will probably have to have additional surgery on it. How can I be removed from LTD if I never healed? I have been told I cannot work because of my back and the situation is magnified by my shoulder issues.

Appeal	04/16/2015 4:20:29PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: outgoing call to ee returning call  
A/S advised once the final decision is rendered, A/S will have ee's file sent out ee thanked A/S

Claim Status	04/16/2015 1:10:36PM	SANDRA QUELLA	Customer Srvc Representative	9452367	Employee
--------------	----------------------	---------------	------------------------------	---------	----------

Topic: TCF EE To check on the status of the claim  
adv EE that the claim is under review and we will be in contact once a decision has been made, EE ack.

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : CLAIM

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	04/15/2015 11:37:22AM	NIAJEA LEE	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee

Topic: tcf ee regarding paperwork

ee called to verify if we received his letter requesting his claim file. Informed ee that we received the letter. EE requested to speak to the dbm, tranferred to the dbm vm.

Claim Status	03/24/2015 9:04:00AM	CHANAVIA BROWN	Senior LTD Claim Analyst	9452367	Employee
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Topic: DBM called Ee back

Advised we will need this in writing. He must note of he needs copies of Policies as well, he states he has them. Asked if he needs mailing address or fax number, he states he has all of Shawndra's information. EE thanked me for my call.

E-mail from Member	03/21/2015 6:54:21PM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: request for copy of file

I would like to request a copy of my Aetna Disability file please. Do I have to submit this in writing?

E-mail from Member	03/18/2015 2:22:11PM	MARIE ANELAS	Customer Srvs Representative	9452367	Employee
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Topic: e-mail from member:

Good afternoon, here are the notes from my office visit with Dr. Sean Kaminsky at Pinnacle Surgical Partners in Hermitage TN.

Summary of Today's Visit

Davis, Arthur DOB REDACTED

Account No 324572

Gender: Male

Race: Black or African American

Ethnicity: Not Hispanic or Latino

Preferred Language: English

03/10/2015 visit with Sean B. Kaminsky, MD

Reason for Visit

NP-RTSHLD

Vitals

. Ht 70 (in)

. Wt 257 (lbs)

. BMI 36.87 (Index)

. Ht-cm 177.8 (cm)

. Wt-kg 116.57 (kg)

Allergies

. N.K.D.A.

Today's Diagnoses Include

. 719.41 Shoulder Pain, Right

. 727.61 Rotator cuff tear, nontraumatic - Right

Medication List

. Start Percocet : 10-325 MG i tablet as needed Orally every 6 hls, 50

Other medications you are on

. Celebrex:

. Cymbalta :

. Tramadol HC1 :

Notes:

I reviewed the results of the MRI study of the right shoulder from March 2, 2015 revealing a massive tear of the supraspinatus and infraspinatus tendons with retraction of approximately 5 cm and muscular atrophy.

Subscapularis tendinosis present. Subacromial and glenohumeral fluid noted. Biceps tear and synovitis present.

, I reviewed the findings and options for treatment such as medication, injections, living with the symptoms.

activity modification, more time, and finally surgery. Patient did not feel that conservative treatment is worked

for him at all. I also discussed various options for surgery including arthroscopic surgery, latissimus transfer

surgeiv, and shoulder arthroplasty. Risks of surgciv were discussed including hut not

limited to bleeding, infection, nerve, ycin, or artery injury, continuing pain, risks of anesthesia includng loss of

life or limb, heart attack, blood clot, seizure, stroke, failure of any surgcy, need for further surgery, and stiffness.

After having this discussion, the patient wants to proceed with surgery. We have completed the paperwork.

answered all questions, provided prescriptions for medication to use post-operatively, my card, anti information

for the surgery center. I encouraged the patient to call me with ans2 questions or concerns about our discussions

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : CLAIM

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Appeal	03/17/2015 4:36:32PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee

Topic: outgoing call to ee to determine if the information provided is all the information ee intends to send, ee stated he is in worse shape now then he was when he went out he feels we have all the info needed he is going for surgery and every doctor indicated he can't work so move forward ee is about to apply for welfare because he has no income he can't afford to wait any further

Appeal	03/17/2015 4:30:31PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: ee confirmed surgery date

Appeal	03/17/2015 4:29:09PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: email. received and reviewed MRI received for review

E-mail from Member	03/11/2015 8:24:44PM	DOMINICA TAYLOR	OR CUSTOMER SRVC REPRESENTA	9452367	Employee
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Topic: update  
My surgery is scheduled for March 25th

E-mail from Member	03/11/2015 8:47:53AM	MARIE ANELAS	Customer Svc Representative	9452367	Employee
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Topic: e-mail from member.  
Today I was seen by Dr. Sean Kaminsky MD, he is a Shoulder specialist at Pinnacle Surgical Partners  
5653 Frist Boulevard  
Ste 731  
Nashville, TN 37064  
615-885-2778 Fax 615-986-6052  
Dr Kaminsky confirmed the MRI findings and set recovery expectations. My right shoulder may never fully recovery and I may need shoulder replacement. I am awaiting a call from his office to set a surgery date ASAP and the expected recovery will be many months.

Appeal	03/04/2015 3:23:40PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: EE confirmed that he did receive A/S vm and thanked A/S for the update but he wanted to give A/S an update to advise that he has now re torn his right rotator cuff and possibly his left and more surgery is to be scheduled, ee stated he is not clear if it was with the recent accident or not but he thinks that his body is breaking down and can't take as much as when he was younger. The surgery will be a reattachment which will be a more intense surgery than before. EE states that he was seen by Dr. Renfro his shoulder surgeon, A/S advised that he is on the list to call for clarification so that information should be obtained if the hcp and peer reviewer is able to connect

Claim Status	03/04/2015 3:12:20PM	MOHINEE VELIAN	USTOMER SERVICE REPRESENTIV	9452367	Employee
--------------	----------------------	----------------	-----------------------------	---------	----------

Topic: CHARLAI IS CALLING EE BACK  
CHARLAI IS CALLING EE BACK

Appeal	03/04/2015 1:59:46PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: outgoing call to ee A/S left vm in response to email  
A/S advised that ext ltr has been sent out to day, a copy of the plan will be sent as well today, however A/S did not indicate that we left a vm on 1/29/15 we were in receipt of the claim so A/S is sorry if ee took it that it's delayed for this reason. If ee has any further questions to please contact A/S

Appeal	03/04/2015 8:14:32AM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: copy of plan is to be sent to ee overnight

Appeal	03/04/2015 8:13:16AM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: email read and  
A/S to contact ee to clarify the discussion as A/S didn't advise ee that a vm was left on 1/29//15 but that the claim was assigned on that date

E-mail from Member	02/25/2015 5:49:26PM	MARIE ANELAS	Customer Svc Representative	9452367	Employee
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Topic: e-mail from member.  
I would like a copy of my plans Long term Disability documents please. I would like the names and contact information of any party involved with my appeal.

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : CLAIM

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
E-mail from Member	02/25/2015 7:55:09AM	MARIE ANELAS	Customer Svc Representative	9452367	Employee

Topic: e-mail from member.

On Feb 20th, I received an email response from Aetna stating "We received the Authorization to Request Protected Health Information, the Disability Appeal Request Form and your medical records for review on 02/09/2015. We will send you a confirmation letter with the details about your claim, once the review has been completed." I was not told anyone had reached out to me, nor did I have any voice messages from Aetna Disability, or Aetna Appeals. Today I received a call from Charlai Lang a Senior LTD Appeals Specialist. The message did not contain her full name or direct contact information. I had to call three different departments to reach her. Ms. Lang is stating she will need an extension on my Appeals process because she tried to contact me on Jan 29th. I do not have a voice message from her, i save all my voice messages from the purchase date of my iPhone. I am struggling to make it and I no longer have any savings. A appeal will push me beyond Dire Straits. I have always contacted Aetna immediately or

Claim Status	02/24/2015 1:43:35PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: outgoing call to ee returning call from vm received

A/S confirmed ee has had another car accident where he was hit from behind again, ee is in therapy and still awaiting a call from the back surgeon's office for a consult, ee states his back is currently locked up and he is not sure it was from slowing down on therapy or the accident, he can't turn to his left or right, they are placing him on muscle relaxers to assist with muscle loosening, ee was using gabapentin and it as helping to reduce his pain and numbness in his leg however ee losing his memory, lost his keys, getting off wrong exits not knowing where he was going to go to places that he frequents, ee also has increased weakness in his right arm and can't type or write for more than a few mins before he feels weakness, ee has not followed up just yet because he was trying to take care of tx for his back and determine if more surgery is needed. EE feels we have everything the test reports shows he has issues with his back and he can't sit or stand for prolonged periods, his doctor has submitted a note reflecting his inability to sit, stand or work, A/S advised that review will be completed and ee will get a ltr requesting additional time so that it can be sent out for peer review and ee's doctors can be contacted, A/S wanted to ensure that prior to completing the review we had everything and ee had not seen the surgeon and a tx plan had been established ee stated he is still waiting for a appt

Claim Status	01/12/2015 12:39:55PM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Contact EE with claim status

DBM contacted EE and informed him that medical information received on 12/23/2014 was insufficient to support ongoing impairment from own occ. DBM informed that claim will be termed as of 1/12/2015. EE inquired that he is still having problems with his back and unable to perform his own occ. DBM informed EE if he disagree with discuss on claim he does have the rights to appeal. EE was informed of his appeals rights.

E-mail from Member	01/07/2015 8:12:29AM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: update on claim

I have been having problems with my right shoulder the past three months.

On December 5th, 2014 I was seen by my Orthopedic Doctor James Renfro. Dr. Renfro took an xray and diagnosed Inflamed AC Joint. Three sessions of PT was suggested, I completed but was still in pain. I received a Cortizone injection in my shoulder on December 26th, 2014. I am still having issues but I am trying to strengthen my shoulder with exercise. I am having extreme pain if I lie on my right shoulder, I cannot lift heavy items and I having shooting pains at times.

Claim Status	12/24/2014 10:23:14AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Acknowledge call

DBM acknowledge call and s/w EE earlier regarding claim status and what is being submitted from treating providers.

E-mail from Member	12/23/2014 4:17:37PM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: update on claim

I just spoke to Dr Yaneyama office they said the have sent information. I was not seen on the dates requested. I was referred to Dr Buechel and my next appointment is in January for Dr Yaneyama. I have asked them to send an update.

Claim Status	12/23/2014 11:25:25AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: RTC to EE

DBM rtc to EE and informed that request from medical records from both his providers were sent out. However, form was received from Dr. Nquist office advising NEW PT's signature. EE informed that he spent the whole mornig yesterday riding to all his treating provider office requesting them to fax over medical records to AETNA. DBM advised that is has not shown up in claim as of yet however, does not mean it hasn't been sent. EE advised that it takes 24- 48 hours to show in claim and once received will call and confirm. EE thanked DBM for calling.

Claim Status	12/18/2014 1:17:35PM	DIANA ACHESON	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: ee sts i sent notes in

ee rcvd letter ee adv would like copy of fax sent to dr Steven Nyquist and any other dr you are req nfo from sent tto the portal so he can take to them he is adv his dr says they have not rcvd anything from aetna please call ee if any questions

Claim Status	12/08/2014 8:18:51AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Acknowledge EE

DBM acknowledge email from EE and no call back is needed.

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : CLAIM

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
E-mail from Member	12/05/2014 6:59:59PM	MARIE ANELAS	Customer Svc Representative	9452367	Employee

Topic: e-mail from member-update

Good afternoon I was seen by my Nuerologist Dr Paul Buechel of KCA Nuerology 4323 Carothers Pkwy, Franklin, TN 37067 (615) 550-1800

Dr Buechel seems to have determined what is causing my Back pain and feet numbing and pain. The new MRI shows Bone Spurs that are inoperatable. When the spurs press on a nerve, I am in pain or develop numbness or pain in my feet. I saw the letter addressed to me online. Dr Nyquist and Yanoyamo will update information but they probably will not do any kind of Disability determination. I will contact their offices to request information updates. I was also seen by Dr. James Renfro concerning some right shoulder complications. I will be participating in physical therapy for the next three weeks and sucess or failure will determine if additional surgery is required. I am available at anytime for a follow up call.

Claim Status	11/24/2014 10:58:32AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Provider
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Topic: No need for call to provider for f/u

No need for f/u call to provider Dr. Steven Nyquist submitted return fax to DBM on 11/21/2014. DBM will send out 30 letter to EE.

Claim Status	11/21/2014 2:39:03PM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Provider
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Topic: Call from provider office

DBM received vm from Amanda at Dr. Tad Yoneyama advising that EE has not been seen during the time frame requesting medicals.

Claim Status	11/06/2014 1:20:29PM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: LTD Claimant Interview

DBM contacted EE to get a better understanding of EE's oow condition. DBM inquired if EE was treating with chiro that he mention in email sent on 09/19/2014. EE informed that he is no longer treating with chiro. EE stated that the spinal deep compression was no good. EE advised that he will be treating with therapist (Jonathan Gish) first OV will be the second week of October. EE will also treat with psychiatrist ( Dr. Steven Nyquist) on 10/13/2014. DBM asked EE what is the condition preventing him from returning to work. EE informed the pain and burning in his feet. EE will be treating with PCP on 10/02/2014. EE informed that his cymbalta has been increase to 90 mg. EE states that he has difficulty with sleeping due to the pain that radiates from his feet to his back. EE informed that he can not sit for prolong period of time due to pain in feet and back. EE states that he can sit for 6-7 minutes before pain. EE advise that he does use the computer a total of 15 minutes a day. EE is capable of drive however only drives to take his son to school. EE states that he attends church but have difficulty with sitting. EE informed that EE has assistance with showering from his ex-wife. EE does nto cook. DBM inquired about classes EE informed that EE would take in the fall at MTSU. EE informed that he has not begin classes but may go in January 2015. EE has been denied. (See More)

Claim Status	10/06/2014 11:39:14AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Acknowledge call

DBM acknowledge call

Claim Status	10/06/2014 11:37:02AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Acknowledge call

DBM acknowledge call

E-mail from Member	10/03/2014 5:51:41AM	DOMINICA TAYLOR	OR CUSTOMER SRVC REPRESENTA	9452367	Employee
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Topic: update

Sorry I did not finish my last message. I am in pain doing my PT. I normally take Tramadol and 2 Arthritis Strength Tylenol, so I should complete class, ice my back and prop up my legs. The true benefits will be enjoying doing something, getting out of the house and not focusing on my pain for a bit.

E-mail from Member	09/30/2014 3:24:41PM	MARIE ANELAS	Customer Svc Representative	9452367	Employee
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Topic: e-mail from member-update

Good morning I would like to update my information concerning my phone conversation this morning. I have been following the Physical Therapy recommendations. I try to exercise, or stretch everyday but sometimes it is too painful. It was recommended to use the Elliptical machine versus a treadmill because the treadmill would be too stressful for my back. Using Tramadol and Arthritis Strength Tylenol I can normally use the machine for 20 minutes. I do my shoulder therapy exercises and I do my stretching at home. I believe the mental therapy will be helpful for my pain. When I first started the Cymbalta I was able to sleep 5-6 hours at night and did not experience burning in my feet all day. Now it appears I have to continue to increase the dosage for relief I believe the mental therapy will help me sleep and I am hopeful a better disposition, attitude and feeling of selfworth will help my daily life. I have become frustrated with medical and chiropractic relief claims but I will not give up hope of recovery.



# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : CLAIM

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	09/30/2014 11:25:52AM	SHAWNDR A LEE	LTD BENEFIT MANAGER	9452367	Employee

Topic: EE contacted for update on status

DBM contacted EE to get a better understanding of EE's oow condition. DBM inquired if EE was treating with chiro that he mention in email sent on 09/19/2014. EE informed that he is no longer treating with chiro. EE stated that the spinal deep compression was no good. EE advised that he will be treating with therapist (Jonathan Gish) first OV will be the second week of October. EE will also treat with psychiatrist ( Dr. Steven Nyquist) on 10/13/2014. DBM asked EE what is the condition preventing him from returning to work. EE informed the pain and burning in his feet.

EE will be treating with PCP on 10/02/2014. EE informed that his cymbalta has been increase to 90 mg. EE states that he has difficulty with sleeping due to the pain that radiates from his feet to his back. EE informed that he can not sit for prolong period of time due to pain in feet and back. EE states that he can sit for 6-7 minutes before pain. EE advise that he does use the computer a total of 15 minutes a day. EE is capable of drive however only drives to take his son to school. EE states that he attends church but have difficulty with sitting. EE informed that EE has assistance with showering from his ex-wife. EE does nto cook.

DBM inquired about classes EE informed that EE would take in the fall at MTSU. EE informed that he has not begin classes but may go in January 2015. EE has been denied.

Claim Status	09/30/2014 10:45:11AM	SHAWNDR A LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Acknowledge call

DBM acknowledge call and will f/u with EE accordinly on disabling condition.

Claim Status	09/26/2014 1:02:13PM	SCHENIA HOLLIDAY	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: status

Tcf Mary Rowland, Lender ph 615-905-6200; calling to confirm length of payments. Per DBM, adv "Approved thru the end of November 2014, at which time we will f/u with provider office to obtain updated information to determine if condition continuously support claim"

E-mail from Member	09/19/2014 8:27:12AM	SUSAN STEWART	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: update from ee

Good afternoon I found the chiropractic treatments to be more harmful then good. My feet seemed to burn more, especially at night. I was not able to sleep following the treatments and it did not provide any back relief. I have discontinued treatment and will be making an appointment with a psychiatrist tomorrow.

Claim Status	09/15/2014 1:27:31PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: updated treatment plan

updated treatment plan

Claim Status	09/15/2014 1:18:43PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: return call to ee

STS left advised ee that Aetna Disability does not make recommendations or referrals for treatment

E-mail from Member	09/11/2014 12:07:45PM	ANASTASIA SNOOK	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: EE TX update

Good morning I have started Spinal Decompression treatment with Dr Derek Totty at Totty Chiropractic of Mt Juliet. 541 N Mt Juliet Rd, Mt Juliet TN 37122 615-758-7101. The session is supposed to run 20 treatments. I am open to any suggestions for pain relief.

E-mail from Member	08/16/2014 12:46:22PM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: update on claim

My next appointment is with Dr. Tad Yoneyama of Heritage Medical Clinic Jan 14th 2015. Current treatment is pain medication. I would be willing to go to any back specialist recommended by Aetna to help with the back pain.

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : CLAIM

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	08/15/2014 1:01:06PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee

Topic: LTD Claimant Interview

Current Treatment: What is your current treatment plan? medication recreation center: physical therapy exercises daily basis. cant afford to continue to pay for pt physical therapy: last treatment may 2014 How do you think your recovery is progressing? not prgressing well. severe back pain What physicians are currently treating you? Dr. Yoneyama When was your last office visit with your physician(s)? July 2014 When is/are your next visit(s) scheduled? What are your current medications and dosages? (If any) tramadol - 50mg twice per day cymbalta -30mg once per day over the counter - arthritis tylenol How has your condition impacted your daily activities? (Housework, driving, child or elder care issues): not able to go many palces. drives son to school, takes a nap. if he has to shop his son or ex wife goes with him to lift bags. Who lives with you? moved in with ex wife to help with his expansives What are your thoughts on returning to work? not able to return to work Have you discussed this with your AP? have not had a discssion What contacts have you made with your employer since your disability.no Would you like any assistance in order to return to work? (Rehab program Note: Some contracts have mandatory rehab): OFF SETS: SSDI / WC / PENSION (Explain the ALLSUP process if applicable): had pycsch exam with ssa What is the status of your Social Security Disability claim? pending What are the dates of birth of your dependent children? REDACTED Are you eligible for a pension / retirement benefit from work? If so, are you currently receiving any benefits? no Are you receiving any benefits from Workers Comp? If so, ask for details including if a settlement is pending. no Assistive devices: not using any at this time.

Claim Status	08/04/2014 12:51:39PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: medication update

ee provided medication update

Claim Status	08/04/2014 12:50:31PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: appts.

dbm sending request to provider

E-mail from Member	08/02/2014 6:35:02PM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: update on claim

I tried to see my Pain Management doctor on Thursday July 31st and unfortunately I was 7 minutes late and she refused to see me. I have requested that my primary care doctor Tad Yoneyama, M.D. - Heritage Medical Associates provide my pain management treatment of Tramadol and Cymbalta versus Dr. Breanna Green. Dr Green has informed me previously that she cannot offer any other solution but pain medication and she charges twice as much for her consultations and I do not have the same personal relationship I have with my primary doctor. I feel he can offer better solutions.

E-mail from Member	07/15/2014 1:55:22PM	ANASTASIA SNOOK	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: EE medication update

I had an appointment with Dr. Tad Yoneyama at Heritage Medical Group, Franklin, TN

He suggested I try Cymbalta again. Eat before taking the medicine and try to work through initial side effects. Started last night and I will pickup script this morning.

Claim Status	07/09/2014 11:04:56AM	SHAWNDR A LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Obtain updated medicals from providers

DBM has request via fax updated medical information from Dr. Breena Green, Dr. Jason Knox, and Dr. Subir Prasad on 07/09/2014.

Claim Status	07/09/2014 11:03:37AM	SHAWNDR A LEE	LTD BENEFIT MANAGER	9452367	Provider
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Topic: Obtain updated medicals from providers

DBM have request updated medicals from Dr. Breena Green, Dr. Jason Knox, and Dr. Subir Prasad thru fax on 07/09/2014.

Claim Status	06/23/2014 10:52:50AM	JACOB PETERSON	SR CUSTOMER SERVICE REP	9452367	Employee
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Topic: TCF APO- Rachna for follow up on the claim for processing of pprwk

TCF APO- Rachna for follow up on the claim for processing of pprwk

APO informed that she had recvd the forms and both were far TOO small

Advised would have the pprwk sent again

n ofurther geustioins

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : CLAIM

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	06/20/2014 11:46:13AM	MARTHA WILEY	Customer Srvc Representative	9452367	Provider

Topic: APS/CLW refaxed to APO  
TCF APO Nancy @ Dr. SUBIR PRASAD

APO called to req the APS/CLW to be refaxed to APO fax#: 615-916-3953 since the faxes rec'd were to small to read/complete.  
CSR refaxed APS/CLW to APO today to fax#: 615-916-3953 To Dr Subir Prasad.  
APO thanked CSR for assistance

Thank you  
Martha Wiley (CSR)

Claim Status	06/17/2014 10:20:08AM	BARTHOLOMAEA GASPARD	INTAKE REPRESENTATIVE	9452367	Employee
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Topic: DR OFFICE FLUP ON FAX REQUEST  
CHARLES REPORTED THAT DR KNOX DIDN'T PUT EE OOW PLS FAX REQUEST TO TREATING DR TO FILL OUT REQUEST

Claim Status	06/16/2014 2:38:47PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: req for medical records  
faxing request for current office visit notes

Claim Status	06/02/2014 3:03:57PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: vob letter  
mailing ee a vob letter

Claim Status	06/02/2014 3:02:57PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: STATUS UPDATE  
sts mailing ee provider form for him to list all new treating providers

Claim Status	06/02/2014 3:01:04PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: vob letter  
mailing ee a vob letter

Claim Status	06/02/2014 2:04:13PM	AKINKAWON TURNER	STD / LOA Benefit Manager	9452367	Employee
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Topic: reviewed  
dbm will contact ee regarding questions for claim

Claim Status	06/02/2014 11:42:01AM	TEMEKA JOHNSON	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: requesting dbm  
tCF ee wanting to speak with dbm.. he has been contacting her for awhile and havent gotten a response. DBM is unavailable so i was directed to reach out to WAnda, which was on the phone. I verified number and told him the dbm will contact him shortly.

E-mail from Member	05/30/2014 8:34:33PM	GLADYS WALTERS	Senior Customer Service Rep	9452367	Employee
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Topic: Member needs income verification letter  
Good morning I sent two requests and have not received a response from either. I would like to email updates directly to my case manager. I do need an income letter.

E-mail from Member	05/28/2014 12:14:46PM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: update on claim  
I would like the email address and contact phone number for my case manager please. I went to my Primary Care physician Dr. Tad Yoneyama at Heritage Medical Clinc. He believes I have a pinched nerve which is causing the painful burning of my feet. He was disappointed in the aloof attitude of Dr. Breanna Green not setting an urgency for the EMG. He is afraid the damage will continue and possible lead to numbness and muscle loss. I have scheduled an appointment with his referral Dr Subir Prasab of Heritage Medical Associates Thursday May 29th at 2:40PM

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : CLAIM

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
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E-mail from Member

05/23/2014 12:35:30PM

THEODORA WILLIAMS

CSR

9452367

Employee

Topic: income letter

Email from member

I am trying to move and they would like a letter stating I will receive benefits beyond 2 yrs if I do not recover. Is this possible?

theodoar williams csr

Claim Status	05/07/2014 3:22:25PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: LTD BENEFIT APPROVAL

dbm advised ee of ltd benefit approval, shared monthly benefit amount and answered all questions

Claim Status	05/07/2014 2:38:55PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: CONFIRMATION OF SX DATE

HELEN FROM DR. RNEFRON'S OFFICE CALLED AND CONFIRMED EE'S LEFT KNEE SX WAS 4/18/2014

Claim Status	05/07/2014 12:44:15PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: req for medical records

faxing request from sx notes to dr renfro

Claim Status	05/07/2014 12:37:45PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: return call to ee

dbm advised ee claim is being reviewed, needed to confirm knee sx date

ee advised knee sx was performed 4/18/2014 and had f/u visit 4/26/2014

Claim Status	05/06/2014 5:26:09PM	KORIE LACHANCE	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: ppwrk needed

TCF EE who was calling to advise he was told he would get a call back today and did not receive on, CSR advised AR is set, EE will receive call back tomorrow. EE understood. CSR advised no determination yet.

Claim Status	05/06/2014 5:19:20PM	SANDRA ATWOOD	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: ee call re status of claim

ee call re status of claim, call dropped while ee on phone, plz cl ee back

Claim Status	05/05/2014 3:48:00PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: return call to ee

DBM ADVISED EE CLAIM WILL BE REVIEWED TOMORROW

E-mail from Member	05/05/2014 1:37:33PM	ANASTASIA SNOOK	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: EE req status

Will there be a decision tomorrow as promised?

Claim Status	04/28/2014 3:42:11PM	AKINKAWON TURNER	STD / LOA Benefit Manager	9452367	Employee
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Topic: rtc to ee

lvmm to advise claim under review ltd dbm will respond once an update is available

E-mail from Member	04/28/2014 1:25:03PM	ANASTASIA SNOOK	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: EE req status

I see my claims representative has changed, is there any update on my claim?

Claim Status	04/03/2014 9:44:01AM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Provider
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Topic: f/u with Dr. Green/PM&R

Sent a request to Dr. Green for APS and evaluation dated 03/25/2014

Claim Status	03/18/2014 3:41:30PM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Employee
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Topic: knee surgery

Claimant informed me that she will have knee surgery April 18, 2014 by Dr. Renfro. Still pending records from Dr. Cote/back surgeon. Will be evaluated by PM&R 04/02/2014.

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : CLAIM

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	03/07/2014 9:27:31AM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Employee

Topic: status

Claimant has advised me via e-mail that Dr. Cote does not do disability paperwork but he will have the medical records faxed to me. He is going to pain mgt today and I requested he sent the contact information for pain mgt physician. I will advise STD.

Claim Status	02/27/2014 3:05:52PM	PAUL FRUGE	Intake Representative	9452367	Employee
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Topic: TCF EE to see if tax form rec, CSR advised rec 2/26.

Claim Status	02/21/2014 9:00:40AM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Employee
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Topic: W4-S

I spoke to claimant and ask him to complete a W4-s. I provided him with the IRS website or the aetna disability website.

Was paperwork received	02/20/2014 1:46:35PM	JEREMY MOORE-WILLIAMS	customer service rep	9452367	Employee
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Topic: ee cking on p/w recieved

csr adv p/w recieved 02/20for reviewing by ltdm

Claim Status	02/14/2014 2:18:45PM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Employee
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Topic: LTD Claimant Interview

Initial Documentation of telephonic interview: Claimant Name: Arthur Davis, Claim 9452367, Dell Inc. -----  
 ----- DO YOU HAVE AETNA HEALTH INSURANCE/ who is your carrier? Currently I have Aetna COBRA. HISTORY / ONSET OF  
 CONDITION: If it began prior to the date of disability, or is long standing, what changed to cause them to stop working? My shoulder tendons fell off both my  
 right and left shoulder. I was just mowing the lawn and lost full use of my arms. Unfortunately I was struck from behind and now have a Herniated Disc in my  
 back which is causing severe pain along with my shoulder difficulties. What is your current medical treatment plan? I have therapy for my left shoulder two days a  
 week. No therapy scheduled for right shoulder yet. Operation was on January 31st 2014. Is condition related to work in any way? Did you file a Workers  
 Compensation claim? Name of company and claim adjuster? No, not work related. Do you have an attorney? Name, address, phone # David Clarke of  
 Murfreesboro TN is representing me concerning the back injury. (615) 796-6299 111 North Maple Street, Murfreesboro, TN 37130 Did you have a non-work  
 related injury or a MVA (Motor Vehicle Accident)? If so, how did the accident occur? When was the accident? Where? City and State? Any legal action pending due  
 to orginal injury? Was a police report filed? If so, where was it filed? The back injury was a motor vechile accident occurred September 27, 2014. Police report  
 was filed with Murfreesboro TN police department. David Clarke is handling the case. Restrictions & Limitations ¿ what did your physician advise you to avoid or  
 that you should limit? I have a planned exercise program for my shoulders and back, I just do my therapy. My back problems have limited my activity as well.  
 Height and weight: 6 feet 236lbs Name of all Medical Providers, provide phone and fax number.- How long have you been treating with them? October of 2014 to  
 present. Dr. James Renfro of Premier Orthopeadics is treating me strictly for my shoulders. Dr. Christopher Kaufman was treating me for my back. November of  
 2014 to January 2015. 394 Harding Place. Nashville, TN 37211. Dr Nicholas Cote has taken over current back treatment. I attend therapy 3 times a week for my  
 back. 1272Garrison Drive, Murfreesboro, TN 37129 Did you discuss your job duties with your provider? Yes Prescription medications/ what conditions are they  
 prescribed for? I take Celebrex for my back and I have a number of painkillers for my shoulders and back when necessary. Describe a Typical Day/ ADLs: Back  
 therapy at 9 or 9:30 until 10:30AM. Shoulder therapy at 11AM until 12PM. I come back home. Any help with household duties? Or shopping? Driving? Yard work?  
 Child or elder care? My son helps with any large item shopping. I can do small item shopping. I don't drive a lot, it hurts my back and my shoulders. I hate to  
 admit I have not cleaned my apartment since second surgery. My son lives with his mother, I am responsible for child support. Volunteer work ¿ where, how  
 often, how many hours? NA RTW (return to work) Status: Projected Date? What are your plans for work? (or retirement?) Dr. James Renfro is predicting a March  
 return date for shoulders. No ETA concerning my back, very difficult typing this email, both shoulders and back pain. Duties and Requirements of your Occupation:  
 At least 8-10 hours a day sitting at desk making calls and typing. Job Status with ER? Are they holding your job? When did you last speak with your supervisor?  
 Dell have offered me a severance package, I have accepted. Will they allow part-time or light duty work or provide any accommodations? Would you like  
 assistance with RTW? NA Earnings: Your employer indicates your earnings as: \$99,101.30/year. Do you agree? Yes Retirem

Claim Status	02/14/2014 10:08:42AM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Employee
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Topic: tPC

Left vmm for claimant to call me back.

Client Name: Dell Inc

(Less Info)  
IHD Consent Effective: N/A

Date of Birth: REDACTED

Age: 52

Gender: Male

Preferred Contact#: REDACTED Phone (Mobile)

Providers

Rehab Vendors

Alerts

Contacts

Active Member Alerts

Submit Action

Create Date	Claim ID	Alert Name	Notification	Created By	Action
▼ 06/01/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	RAJESH KUMAR	Please Select ▼
▼ 05/29/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	ANKESH KUMAR	Please Select ▼
▼ 05/27/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	NAVTEJ BHADUR	Please Select ▼
▼ 04/28/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	JASEEM ANSARI	Please Select ▼
▼ 04/28/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	JASEEM ANSARI	Please Select ▼
▼ 02/09/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	PAVAN KUMAR	Please Select ▼
▼ 01/14/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	BHUPENDRA SINGH	Please Select ▼
▼ 01/08/2015	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	ARUN CHAWLA	Please Select ▼
▼ 12/26/2014	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	ROHIT SINGH	Please Select ▼
▼ 09/29/2014	9452367	<a href="#">Aetna received information regarding your claim</a>	Not Being Sent	YADAV VIKAS	Please Select ▼

Alerts And Notification History

Expand All Details

View

All

Show 10

Notes

<< < 1 2 3 4 5 of 5 > >>

Create Date	Claim ID	Alert Name	Notification (Y/N)	Created By	Dismiss Date
▼ 04/30/2015	9452367	Aetna received information regarding your claim	Not Being Sent	RAJESH KUMAR	05/03/2015
▼ 04/03/2015	9452367	Aetna received information regarding your claim	Not Being Sent	KAPIL SINGH	04/18/2015
▼ 03/20/2015	9452367	Aetna received information regarding your claim	Not Being Sent	DASHRAT SINGHBIST	04/18/2015
▼ 03/09/2015	9452367	Aetna received information regarding your claim	Not Being Sent	BHUPENDRA SINGH	03/15/2015
▼ 02/09/2015	9452367	Aetna received information regarding your claim	Not Being Sent	WEB SERVICE	02/17/2015
▼ 02/09/2015	9452367	Aetna received information regarding your claim	Not Being Sent	WEB SERVICE	02/17/2015
▼ 01/30/2015	9452367	Authorization to Request Health Information	Not Being Sent	CANDICE HOY	02/09/2015

▼ 01/30/2015	9452367	Disability Appeal Request Form	Not Being Sent	CANDICE HOY	02/09/2015
▼ 01/29/2015	9452367	Aetna received information regarding your claim	Not Being Sent	YADAV VIKAS	02/17/2015
▼ 01/13/2015	9452367	Aetna has issued a payment	Not Being Sent	WKAB SYSTEM	02/17/2015

Client Name: Dell Inc

(Less Info)  
IHD Consent Effective: N/A

Date of Birth: REDACTED

Age: 52

Gender: Male

Preferred Contact#: REDACTED Phone (Mobile)

Providers

Rehab Vendors

Alerts

Contacts

▲ Manage Notes: ADD NEW

Subject		Create Date	Creator	Title	Claim #	Contact
* Claim Status	▼	10/6/2015 5:04:13 AM	PRAKASH PRASAD	PARALEGAL II	EMPLOYEE	* Employee ▼

Topic:\*

Save See Reminders Cancel

▲ Follow Up Required

Task Name	Schedule Date	Assign Owner	Memo
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☐ Action Required

10/06/2015

PRASAD,PRAKASH

Select

☐ Complaint Follow Up Required

10/06/2015

PRASAD,PRAKASH

Select

☐ Email Provider Forms

10/06/2015

PRASAD,PRAKASH

Select

☐ Email Supplemental Forms

10/06/2015

PRASAD,PRAKASH

Select

☐ Employee Contact

10/06/2015

PRASAD,PRAKASH

Select

☐ Employer Contact

10/06/2015

PRASAD,PRAKASH

Select

☐ Faxed Form Request APS/BHCS

10/06/2015

PRASAD,PRAKASH

Select

Save &amp; Create task

Contact Notes History

Expand All Details

View 

All

Contact Filter 

All

Subject Filter 

All

Show 

10

 Notes

<< < 1 2 3 4 5 of 15 > >>

Subject	Last Update Date	Creator	Title	Claim #	Contact
▼ Appeal	5/28/2015 9:26:22 AM	CHARLAI LANG	Disability Appeals Specialist	9452367 (LTD) Closed	Other
Topic: outgoing call to Atty office					
▼ Claim Status	5/27/2015 11:57:01 AM	PATRICIA HICKEY	Customer Svc Representative	9452367 (LTD) Closed	Other
Topic: speak to appeals analyst					
▼ Appeal	4/24/2015 11:50:48 AM	CHARLAI LANG	Disability Appeals Specialist	9452367 (LTD) Closed	Employee
Topic: outgoing call to ee returning call					
▼ E-mail from Member	4/23/2015 5:01:48 PM	MARIE ANELAS	Customer Svc Representative	9452367 (LTD) Closed	Employee
Topic: e-mail from member-					
▼ E-mail from Member	4/20/2015 6:17:19 PM	MARIE ANELAS	Customer Svc Representative	9452367 (LTD) Closed	Employee
Topic: e-mail from member.					
▼ Appeal	4/20/2015 5:56:34 PM	CHARLAI LANG	Disability Appeals Specialist	9452367 (LTD) Closed	Employee
Topic: call returned					
▼ Appeal	4/20/2015 5:55:09 PM	CHARLAI LANG	Disability Appeals Specialist	9452367 (LTD) Closed	Employee
Topic: outgoing call to ee returning call					
▼ E-mail from Member	4/18/2015 9:34:29 AM	SHERRI MCINNES	Customer Service Rep	9452367 (LTD) Closed	Employee
Topic: update on claim					
▼ Appeal	4/16/2015 4:20:29 PM	CHARLAI LANG	Disability Appeals Specialist	9452367 (LTD) Closed	Employee
Topic: outgoing call to ee returning call					
▼ Claim Status	4/16/2015 1:10:36 PM	SANDRA QUELLA	Customer Svc Representative	9452367 (LTD) Closed	Employee
Topic: TCF EE To check on the status of the claim					

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
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Topic: outgoing call to Atty office  
spoke with Nikki to leave msg for atty, on A/S vm the atty was requesting re open of the appeal and a copy of the file, Atty indicated that she just got on board to represent ee and A/S advised the file is already closed. The decision ltr went out on 4/23/15 and ee had already requested a copy of the filed on 4/13/15. the Atty does have the option to file suit but we can't open the case again and give more time after it's been closed

Claim Status	05/27/2015 11:57:01AM	PATRICIA HICKEY	Customer Srvc Representative	9452367	Other
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Topic: speak to appeals analyst  
Barbara atty for EE asked to speak to appeals analyst. She was unavailable. Xfrd to vm  
  
authorization form date 4/30 image 17415744

Barbara 615 234 6000  
Cody Allison

Appeal	04/24/2015 11:50:48AM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: outgoing call to ee returning call  
A/S advised that unfortunately the medical documentation did not support ongoing impairment and ltr was mailed today, ee stated he just want a copy of his file with direction on how to file suit. A/S advised that ee would need to take file to any atty who will give ee direction on how to file suit ee thanked A/S

E-mail from Member	04/23/2015 5:01:48PM	MARIE ANELAS	Customer Srvc Representative	9452367	Employee
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Topic: e-mail from member-  
Good morning I spoke to me claims manager this week and was told I would get a decision letter on the 22nd. I do not see a generated letter?

E-mail from Member	04/20/2015 6:17:19PM	MARIE ANELAS	Customer Srvc Representative	9452367	Employee
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Topic: e-mail from member.  
I submitted a request via Document Download. I am submitted here also.  
Appeal Status Appeal Decision Due Date  
Active Upheld 04/22/2015  
Good morning Charlai, I see the decision has been made concerning my appeal. Are there any additional  
Appeal options? If I do not have any appeal options please send me the Denial letter and my Aetna records thank you.  
Arthur Cyril Davis Jr.

Appeal	04/20/2015 5:56:34PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: call returned  
file will be released after decision is finalized

Appeal	04/20/2015 5:55:09PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: outgoing call to ee returning call  
To advise that the decision ltr is under review and A/S will release a copy of the medical file once the ltr is released ee thanked A/S

E-mail from Member	04/18/2015 9:34:29AM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: update on claim  
Good afternoon today I dropped off updated paperwork to the Social security administration. Looking at my timeline, my LTD was approved through Aetna for my shoulder issues. I was out on under doctors care until May 23rd 2014 specifically for my shoulders. Looking at notes from Physical Therapy I was complaining about my shoulders up to the release date. I complained to my surgeon that I was hearing popping and clicking noises but was told it would go away as my shoulders strengthen. 5 months later I was back to his office and two months after I was scheduled for another reattachment. It does not appear that my shoulders healed properly and based on my new surgeons findings, my right shoulder may not return to normal. My left shoulder is still popping and I have occasional pain and I will probably have to have additional surgery on it. How can I be removed from LTD if I never healed? I have been told I cannot work because of my back and the situation is magnified by my shoulder issues.

Appeal	04/16/2015 4:20:29PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: outgoing call to ee returning call  
A/S advised once the final decision is rendered, A/S will have ee's file sent out ee thanked A/S

Claim Status	04/16/2015 1:10:36PM	SANDRA QUELLA	Customer Srvc Representative	9452367	Employee
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Topic: TCF EE To check on the status of the claim  
adv EE that the claim is under review and we will be in contact once a decision has been made, EE ack.

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	04/15/2015 11:37:22AM	NIAJEA LEE	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee

Topic: tcf ee regarding paperwork

ee called to verify if we received his letter requesting his claim file. Informed ee that we received the letter. EE requested to speak to the dbm, tranferred to the dbm vm.

Claim Status	03/24/2015 9:04:00AM	CHANAVIA BROWN	Senior LTD Claim Analyst	9452367	Employee
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Topic: DBM called Ee back

Advised we will need this in writing. He must note of he needs copies of Policies as well, he states he has them. Asked if he needs mailing address or fax number, he states he has all of Shawndra's information. EE thanked me for my call.

E-mail from Member	03/21/2015 6:54:21PM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: request for copy of file

I would like to request a copy of my Aetna Disability file please. Do I have to submit this in writing?

E-mail from Member	03/18/2015 2:22:11PM	MARIE ANELAS	Customer Srvs Representative	9452367	Employee
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Topic: e-mail from member:

Good afternoon, here are the notes from my office visit with Dr. Sean Kaminsky at Pinnacle Surgical Partners in Hermitage TN.

Summary of Today's Visit

Davis, Arthur DOB: [REDACTED]

Account No 324572

Gender: Male

Race: Black or African American

Ethnicity: Not Hispanic or Latino

Preferred Language: English

03/10/2015 visit with Sean B. Kaminsky, MD

Reason for Visit

NP-RTSHLD

Vitals

. Ht 70 (in)

. Wt 257 (lbs)

. BMI 36.87 (Index)

. Ht-cm 177.8 (cm)

. Wt-kg 116.57 (kg)

Allergies

. N.K.D.A.

Today's Diagnoses Include

. 719.41 Shoulder Pain, Right

. 727.61 Rotator cuff tear, nontraumatic - Right

Medication List

. Start Percocet : 10-325 MG i tablet as needed Orally every 6 hls, 50

Other medications you are on

. Celebrex:

. Cymbalta :

. Tramadol HC1 :

Notes:

I reviewed the results of the MRI study of the right shoulder from March 2, 2015 revealing a massive tear of the supraspinatus and infraspinatus tendons with retraction of approximately 5 cm and muscular atrophy.

Subscapularis tendinosis present. Subacromial and glenohumeral fluid noted. Biceps tear and synovitis present.

, I reviewed the findings and options for treatment such as medication, injections, living with the symptoms.

activity modification, more time, and finally surgery. Patient did not feel that conservative treatment is worked

for him at all. I also discussed various options for surgery including arthroscopic surgery, latissimus transfer

surgeiv, and shoulder arthroplasty. Risks of surgciv were discussed including hut not

limited to bleeding, infection, nerve, ycin, or artery injury, continuing pain, risks of anesthesia includng loss of

life or limb, heart attack, blood clot, seizure, stroke, failure of any surgcy, need for further surgery, and stiffness.

After having this discussion, the patient wants to proceed with surgery. We have completed the paperwork.

answered all questions, provided prescriptions for medication to use post-operatively, my card, anti information

for the surgery center. I encouraged the patient to call me with ans2 questions or concerns about our discussions

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Appeal	03/17/2015 4:36:32PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee

Topic: outgoing call to ee to determine if the information provided is all the information ee intends to send, ee stated he is in worse shape now then he was when he went out he feels we have all the info needed he is going for surgery and every doctor indicated he can't work so move forward ee is about to apply for welfare because he has no income he can't afford to wait any further

Appeal	03/17/2015 4:30:31PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: ee confirmed surgery date

Appeal	03/17/2015 4:29:09PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: email. received and reviewed MRI received for review

E-mail from Member	03/11/2015 8:24:44PM	DOMINICA TAYLOR	OR CUSTOMER SRVC REPRESENTA	9452367	Employee
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Topic: update  
My surgery is scheduled for March 25th

E-mail from Member	03/11/2015 8:47:53AM	MARIE ANELAS	Customer Srvc Representative	9452367	Employee
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Topic: e-mail from member.  
Today I was seen by Dr. Sean Kaminsky MD, he is a Shoulder specialist at Pinnacle Surgical Partners  
5653 Frist Boulevard  
Ste 731  
Nashville, TN 37064  
615-885-2778 Fax 615-986-6052  
Dr Kaminsky confirmed the MRI findings and set recovery expectations. My right shoulder may never fully recovery and I may need shoulder replacement. I am awaiting a call from his office to set a surgery date ASAP and the expected recovery will be many months.

Appeal	03/04/2015 3:23:40PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: EE confirmed that he did receive A/S vm and thanked A/S for the update but he wanted to give A/S an update to advise that he has now re torn his right rotator cuff and possibly his left and more surgery is to be scheduled, ee stated he is not clear if it was with the recent accident or not but he thinks that his body is breaking down and can't take as much as when he was younger. The surgery will be a reattachment which will be a more intense surgery than before. EE states that he was seen by Dr. Renfro his shoulder surgeon, A/S advised that he is on the list to call for clarification so that information should be obtained if the hcp and peer reviewer is able to connect

Claim Status	03/04/2015 3:12:20PM	MOHINEE VELIAN	USTOMER SERVICE REPRESENTIV	9452367	Employee
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Topic: CHARLAI IS CALLING EE BACK  
CHARLAI IS CALLING EE BACK

Appeal	03/04/2015 1:59:46PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: outgoing call to ee A/S left vm in response to email  
A/S advised that ext ltr has been sent out to day, a copy of the plan will be sent as well today, however A/S did not indicate that we left a vm on 1/29/15 we were in receipt of the claim so A/S is sorry if ee took it that it's delayed for this reason. If ee has any further questions to please contact A/S

Appeal	03/04/2015 8:14:32AM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: copy of plan is to be sent to ee overnight

Appeal	03/04/2015 8:13:16AM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: email read and  
A/S to contact ee to clarify the discussion as A/S didn't advise ee that a vm was left on 1/29//15 but that the claim was assigned on that date

E-mail from Member	02/25/2015 5:49:26PM	MARIE ANELAS	Customer Srvc Representative	9452367	Employee
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Topic: e-mail from member.  
I would like a copy of my plans Long term Disability documents please. I would like the names and contact information of any party involved with my appeal.

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
E-mail from Member	02/25/2015 7:55:09AM	MARIE ANELAS	Customer Svc Representative	9452367	Employee

Topic: e-mail from member.

On Feb 20th, I received an email response from Aetna stating "We received the Authorization to Request Protected Health Information, the Disability Appeal Request Form and your medical records for review on 02/09/2015. We will send you a confirmation letter with the details about your claim, once the review has been completed." I was not told anyone had reached out to me, nor did I have any voice messages from Aetna Disability, or Aetna Appeals. Today I received a call from Charlai Lang a Senior LTD Appeals Specialist. The message did not contain her full name or direct contact information. I had to call three different departments to reach her. Ms. Lang is stating she will need an extension on my Appeals process because she tried to contact me on Jan 29th. I do not have a voice message from her, i save all my voice messages from the purchase date of my iPhone. I am struggling to make it and I no longer have any savings. A appeal will push me beyond Dire Straits. I have always contacted Aetna immediately or

Claim Status	02/24/2015 1:43:35PM	CHARLAI LANG	Disability Appeals Specialist	9452367	Employee
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Topic: outgoing call to ee returning call from vm received

A/S confirmed ee has had another car accident where he was hit from behind again, ee is in therapy and still awaiting a call from the back surgeon's office for a consult, ee states his back is currently locked up and he is not sure it was from slowing down on therapy or the accident, he can't turn to his left or right, they are placing him on muscle relaxers to assist with muscle loosening, ee was using gabapentin and it as helping to reduce his pain and numbness in his leg however ee losing his memory, lost his keys, getting off wrong exits not knowing where he was going to go to places that he frequents, ee also has increased weakness in his right arm and can't type or write for more than a few mins before he feels weakness, ee has not followed up just yet because he was trying to take care of tx for his back and determine if more surgery is needed. EE feels we have everything the test reports shows he has issues with his back and he can't sit or stand for prolonged periods, his doctor has submitted a note reflecting his inability to sit, stand or work, A/S advised that review will be completed and ee will get a ltr requesting additional time so that it can be sent out for peer review and ee's doctors can be contacted, A/S wanted to ensure that prior to completing the review we had everything and ee had not seen the surgeon and a tx plan had been established ee stated he is still waiting for a appt

Claim Status	01/12/2015 12:39:55PM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Contact EE with claim status

DBM contacted EE and informed him that medical information received on 12/23/2014 was insufficient to support ongoing impairment from own occ. DBM informed that claim will be termed as of 1/12/2015. EE inquired that he is still having problems with his back and unable to perform his own occ. DBM informed EE if he disagree with discuss on claim he does have the rights to appeal. EE was informed of his appeals rights.

E-mail from Member	01/07/2015 8:12:29AM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: update on claim

I have been having problems with my right shoulder the past three months.

On December 5th, 2014 I was seen by my Orthopedic Doctor James Renfro. Dr. Renfro took an xray and diagnosed Inflamed AC Joint. Three sessions of PT was suggested, I completed but was still in pain. I received a Cortizone injection in my shoulder on December 26th, 2014. I am still having issues but I am trying to strengthen my shoulder with exercise. I am having extreme pain if I lie on my right shoulder, I cannot lift heavy items and I having shooting pains at times.

Claim Status	12/24/2014 10:23:14AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Acknowledge call

DBM acknowledge call and s/w EE earlier regarding claim status and what is being submitted from treating providers.

E-mail from Member	12/23/2014 4:17:37PM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: update on claim

I just spoke to Dr Yaneyama office they said the have sent information. I was not seen on the dates requested. I was referred to Dr Buechel and my next appointment is in January for Dr Yaneyama. I have asked them to send an update.

Claim Status	12/23/2014 11:25:25AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: RTC to EE

DBM rtc to EE and informed that request from medical records from both his providers were sent out. However, form was received from Dr. Nquist office advising NEW PT's signature. EE informed that he spent the whole mornig yesterday riding to all his treating provider office requesting them to fax over medical records to AETNA. DBM advised that is has not shown up in claim as of yet however, does not mean it hasn't been sent. EE advised that it takes 24- 48 hours to show in claim and once received will call and confirm. EE thanked DBM for calling.

Claim Status	12/18/2014 1:17:35PM	DIANA ACHESON	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: ee sts i sent notes in

ee rcvd letter ee adv would like copy of fax sent to dr Steven Nyquist and any other dr you are req nfo from sent tto the portal so he can take to them he is adv his dr says they have not rcvd anything from aetna please call ee if any questions

Claim Status	12/08/2014 8:18:51AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Acknowledge EE

DBM acknowledge email from EE and no call back is needed.

# Central Note System - View All Report

[Click Here To Access The Excel Export View](#)

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
E-mail from Member	12/05/2014 6:59:59PM	MARIE ANELAS	Customer Svc Representative	9452367	Employee

Topic: e-mail from member-update

Good afternoon I was seen by my Nuerologist Dr Paul Buechel of KCA Nuerology 4323 Carothers Pkwy, Franklin, TN 37067 (615) 550-1800

Dr Buechel seems to have determined what is causing my Back pain and feet numbing and pain. The new MRI shows Bone Spurs that are inoperatable. When the spurs press on a nerve, I am in pain or develop numbness or pain in my feet. I saw the letter addressed to me online. Dr Nyquist and Yanoyamo will update information but they probably will not do any kind of Disability determination. I will contact their offices to request information updates. I was also seen by Dr. James Renfro concerning some right shoulder complications. I will be participating in physical therapy for the next three weeks and sucess or failure will determine if additional surgery is required. I am available at anytime for a follow up call.

Claim Status	11/24/2014 10:58:32AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Provider
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Topic: No need for call to provider for f/u

No need for f/u call to provider Dr. Steven Nyquist submitted return fax to DBM on 11/21/2014. DBM will send out 30 letter to EE.

Claim Status	11/21/2014 2:39:03PM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Provider
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Topic: Call from provider office

DBM received vm from Amanda at Dr. Tad Yoneyama advising that EE has not been seen during the time frame requesting medicals.

Claim Status	11/06/2014 1:20:29PM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: LTD Claimant Interview

DBM contacted EE to get a better understanding of EE's oow condition. DBM inquired if EE was treating with chiro that he mention in email sent on 09/19/2014. EE informed that he is no longer treating with chiro. EE stated that the spinal deep compression was no good. EE advised that he will be treating with therapist (Jonathan Gish) first OV will be the second week of October. EE will also treat with psychiatrist ( Dr. Steven Nyquist) on 10/13/2014. DBM asked EE what is the condition preventing him from returning to work. EE informed the pain and burning in his feet. EE will be treating with PCP on 10/02/2014. EE informed that his cymbalta has been increase to 90 mg. EE states that he has difficulty with sleeping due to the pain that radiates from his feet to his back. EE informed that he can not sit for prolong period of time due to pain in feet and back. EE states that he can sit for 6-7 minutes before pain. EE advise that he does use the computer a total of 15 minutes a day. EE is capable of drive however only drives to take his son to school. EE states that he attends church but have difficulty with sitting. EE informed that EE has assistance with showering from his ex-wife. EE does nto cook. DBM inquired about classes EE informed that EE would take in the fall at MTSU. EE informed that he has not begin classes but may go in January 2015. EE has been denied. (See More)

Claim Status	10/06/2014 11:39:14AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Acknowledge call

DBM acknowledge call

Claim Status	10/06/2014 11:37:02AM	SHAWNDR LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Acknowledge call

DBM acknowledge call

E-mail from Member	10/03/2014 5:51:41AM	DOMINICA TAYLOR	OR CUSTOMER SRVC REPRESENTA	9452367	Employee
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Topic: update

Sorry I did not finish my last message. I am in pain doing my PT. I normally take Tramadol and 2 Arthritis Strength Tylenol, so I should complete class, ice my back and prop up my legs. The true benefits will be enjoying doing something, getting out of the house and not focusing on my pain for a bit.

E-mail from Member	09/30/2014 3:24:41PM	MARIE ANELAS	Customer Svc Representative	9452367	Employee
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Topic: e-mail from member-update

Good morning I would like to update my information concerning my phone conversation this morning. I have been following the Physical Therapy recommendations. I try to exercise, or stretch everyday but sometimes it is too painful. It was recommended to use the Elliptical machine versus a treadmill because the treadmill would be too stressful for my back. Using Tramadol and Arthritis Strength Tylenol I can normally use the machine for 20 minutes. I do my shoulder therapy exercises and I do my stretching at home. I believe the mental therapy will be helpful for my pain. When I first started the Cymbalta I was able to sleep 5-6 hours at night and did not experience burning in my feet all day. Now it appears I have to continue to increase the dosage for relief I believe the mental therapy will help me sleep and I am hopeful a better disposition, attitude and feeling of selfworth will help my daily life. I have become frustrated with medical and chiropractic relief claims but I will not give up hope of recovery.



# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

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## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	09/30/2014 11:25:52AM	SHAWNDR A LEE	LTD BENEFIT MANAGER	9452367	Employee

Topic: EE contacted for update on status

DBM contacted EE to get a better understanding of EE's oow condition. DBM inquired if EE was treating with chiro that he mention in email sent on 09/19/2014. EE informed that he is no longer treating with chiro. EE stated that the spinal deep compression was no good. EE advised that he will be treating with therapist (Jonathan Gish) first OV will be the second week of October. EE will also treat with psychiatrist ( Dr. Steven Nyquist) on 10/13/2014. DBM asked EE what is the condition preventing him from returning to work. EE informed the pain and burning in his feet.

EE will be treating with PCP on 10/02/2014. EE informed that his cymbalta has been increase to 90 mg. EE states that he has difficulty with sleeping due to the pain that radiates from his feet to his back. EE informed that he can not sit for prolong period of time due to pain in feet and back. EE states that he can sit for 6-7 minutes before pain. EE advise that he does use the computer a total of 15 minutes a day. EE is capable of drive however only drives to take his son to school. EE states that he attends church but have difficulty with sitting. EE informed that EE has assistance with showering from his ex-wife. EE does nto cook.

DBM inquired about classes EE informed that EE would take in the fall at MTSU. EE informed that he has not begin classes but may go in January 2015. EE has been denied.

Claim Status	09/30/2014 10:45:11AM	SHAWNDR A LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Acknowledge call

DBM acknowledge call and will f/u with EE accordinly on disabling condition.

Claim Status	09/26/2014 1:02:13PM	SCHENIA HOLLIDAY	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: status

Tcf Mary Rowland, Lender ph 615-905-6200; calling to confirm length of payments. Per DBM, adv "Approved thru the end of November 2014, at which time we will f/u with provider office to obtain updated information to determine if condition continuously support claim"

E-mail from Member	09/19/2014 8:27:12AM	SUSAN STEWART	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: update from ee

Good afternoon I found the chiropractic treatments to be more harmful then good. My feet seemed to burn more, especially at night. I was not able to sleep following the treatments and it did not provide any back relief. I have discontinued treatment and will be making an appointment with a psychiatrist tomorrow.

Claim Status	09/15/2014 1:27:31PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: updated treatment plan

updated treatment plan

Claim Status	09/15/2014 1:18:43PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: return call to ee

STS left advised ee that Aetna Disability does not make recommendations or referrals for treatment

E-mail from Member	09/11/2014 12:07:45PM	ANASTASIA SNOOK	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: EE TX update

Good morning I have started Spinal Decompression treatment with Dr Derek Totty at Totty Chiropractic of Mt Juliet. 541 N Mt Juliet Rd, Mt Juliet TN 37122 615-758-7101. The session is supposed to run 20 treatments. I am open to any suggestions for pain relief.

E-mail from Member	08/16/2014 12:46:22PM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: update on claim

My next appointment is with Dr. Tad Yoneyama of Heritage Medical Clinic Jan 14th 2015. Current treatment is pain medication. I would be willing to go to any back specialist recommended by Aetna to help with the back pain.

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

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## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	08/15/2014 1:01:06PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee

Topic: LTD Claimant Interview

Current Treatment: What is your current treatment plan? medication recreation center: physical therapy exercises daily basis. cant afford to continue to pay for pt physical therapy: last treatment may 2014 How do you think your recovery is progressing? not prgressing well. severe back pain What physicians are currently treating you? Dr. Yoneyama When was your last office visit with your physician(s)? July 2014 When is/are your next visit(s) scheduled? What are your current medications and dosages? (If any) tramadol - 50mg twice per day cymbalta -30mg once per day over the counter - arthritis tylenol How has your condition impacted your daily activities? (Housework, driving, child or elder care issues): not able to go many palces. drives son to school, takes a nap. if he has to shop his son or ex wife goes with him to lift bags. Who lives with you? moved in with ex wife to help with his expansives What are your thoughts on returning to work? not able to return to work Have you discussed this with your AP? have not had a discssion What contacts have you made with your employer since your disability.no Would you like any assistance in order to return to work? (Rehab program Note: Some contracts have mandatory rehab): OFF SETS: SSDI / WC / PENSION (Explain the ALLSUP process if applicable): had pycsch exam with ssa What is the status of your Social Security Disability claim? pending What are the dates of birth of your dependent children? REDACTED Are you eligible for a pension / retirement benefit from work? If so, are you currently receiving any benefits? no Are you receiving any benefits from Workers Comp? If so, ask for details including if a settlement is pending. no Assistive devices: not using any at this time.

Claim Status	08/04/2014 12:51:39PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: medication update

ee provided medication update

Claim Status	08/04/2014 12:50:31PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: appts.

dbm sending request to provider

E-mail from Member	08/02/2014 6:35:02PM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: update on claim

I tried to see my Pain Management doctor on Thursday July 31st and unfortunately I was 7 minutes late and she refused to see me. I have requested that my primary care doctor Tad Yoneyama, M.D. - Heritage Medical Associates provide my pain management treatment of Tramadol and Cymbalta versus Dr. Breanna Green. Dr Green has informed me previously that she cannot offer any other solution but pain medication and she charges twice as much for her consultations and I do not have the same personal relationship I have with my primary doctor. I feel he can offer better solutions.

E-mail from Member	07/15/2014 1:55:22PM	ANASTASIA SNOOK	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: EE medication update

I had an appointment with Dr. Tad Yoneyama at Heritage Medical Group, Franklin, TN

He suggested I try Cymbalta again. Eat before taking the medicine and try to work through initial side effects. Started last night and I will pickup script this morning.

Claim Status	07/09/2014 11:04:56AM	SHAWNDR A LEE	LTD BENEFIT MANAGER	9452367	Employee
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Topic: Obtain updated medicals from providers

DBM has request via fax updated medical information from Dr. Breena Green, Dr. Jason Knox, and Dr. Subir Prasad on 07/09/2014.

Claim Status	07/09/2014 11:03:37AM	SHAWNDR A LEE	LTD BENEFIT MANAGER	9452367	Provider
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Topic: Obtain updated medicals from providers

DBM have request updated medicals from Dr. Breena Green, Dr. Jason Knox, and Dr. Subir Prasad thru fax on 07/09/2014.

Claim Status	06/23/2014 10:52:50AM	JACOB PETERSON	SR CUSTOMER SERVICE REP	9452367	Employee
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Topic: TCF APO- Rachna for follow up on the claim for processing of pprwk

TCF APO- Rachna for follow up on the claim for processing of pprwk

APO informed that she had recvd the forms and both were far TOO small

Advised would have the pprwk sent again

n ofurther geustoions



# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	06/20/2014 11:46:13AM	MARTHA WILEY	Customer Svc Representative	9452367	Provider

Topic: APS/CLW refaxed to APO  
TCF APO Nancy @ Dr. SUBIR PRASAD

APO called to req the APS/CLW to be refaxed to APO fax#: 615-916-3953 since the faxes rec'd were to small to read/complete.  
CSR refaxed APS/CLW to APO today to fax#: 615-916-3953 To Dr Subir Prasad.  
APO thanked CSR for assistance

Thank you  
Martha Wiley (CSR)

Claim Status	06/17/2014 10:20:08AM	BARTHOLOMAEA GASPARD	INTAKE REPRESENTATIVE	9452367	Employee
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Topic: DR OFFICE FLUP ON FAX REQUEST  
CHARLES REPORTED THAT DR KNOX DIDN;T PUT EE OOW PLS FAX REQUEST TO TREATING DR TO FILL OUT REQUEST

Claim Status	06/16/2014 2:38:47PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: req for medical records  
faxing request for current office visit notes

Claim Status	06/02/2014 3:03:57PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: vob letter  
mailing ee a vob letter

Claim Status	06/02/2014 3:02:57PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: STATUS UPDATE  
sts mailing ee provider form for him to list all new treating providers

Claim Status	06/02/2014 3:01:04PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: vob letter  
mailing ee a vob letter

Claim Status	06/02/2014 2:04:13PM	AKINKAWON TURNER	STD / LOA Benefit Manager	9452367	Employee
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Topic: reviewed  
dbm will contact ee regarding questions for claim

Claim Status	06/02/2014 11:42:01AM	TEMEKA JOHNSON	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: requesting dbm  
tCF ee wanting to speak with dbm.. he has been contacting her for awhile and havent gotten a response. DBM is unavailable so i was directed to reach out to WAnda, which was on the phone. I verified number and told him the dbm will contact him shortly.

E-mail from Member	05/30/2014 8:34:33PM	GLADYS WALTERS	Senior Customer Service Rep	9452367	Employee
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Topic: Member needs income verification letter  
Good morning I sent two requests and have not received a response from either. I would like to email updates directly to my case manager. I do need an income letter.

E-mail from Member	05/28/2014 12:14:46PM	SHERRI MCINNES	Customer Service Rep	9452367	Employee
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Topic: update on claim  
I would like the email address and contact phone number for my case manager please. I went to my Primary Care physician Dr. Tad Yoneyama at Heritage Medical Clinc. He believes I have a pinched nerve which is causing the painful burning of my feet. He was disappointed in the aloof attitude of Dr. Breanna Green not setting an urgency for the EMG. He is afraid the damage will continue and possible lead to numbness and muscle loss. I have scheduled an appointment with his referral Dr Subir Prasab of Heritage Medical Associates Thursday May 29th at 2:40PM

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
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E-mail from Member  
Topic: income letter  
Email from member

I am trying to move and they would like a letter stating I will receive benefits beyond 2 yrs if I do not recover. Is this possible?

theo doar williams csr

Claim Status	05/07/2014 3:22:25PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: LTD BENEFIT APPROVAL  
dbm advised ee of ltd benefit approval, shared monthly benefit amount and answered all questions

Claim Status	05/07/2014 2:38:55PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: CONFIRMATION OF SX DATE  
HELEN FROM DR. RNEFRON'S OFFICE CALLED AND CONFIRMED EE'S LEFT KNEE SX WAS 4/18/2014

Claim Status	05/07/2014 12:44:15PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: req for medical records  
faxing request from sx notes to dr renfro

Claim Status	05/07/2014 12:37:45PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: return call to ee  
dbm advised ee claim is being reviewed, needed to confirm knee sx date  
ee advised knee sx was performed 4/18/2014 and had f/u visit 4/26/2014

Claim Status	05/06/2014 5:26:09PM	KORIE LACHANCE	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: ppwrk needed  
TCF EE who was calling to advise he was told he would get a call back today and did not receive on, CSR advised AR is set, EE will receive call back tomorrow. EE understood. CSR advised no determination yet.

Claim Status	05/06/2014 5:19:20PM	SANDRA ATWOOD	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: ee call re status of claim  
ee call re status of claim, call dropped while ee on phone, plz cll ee back

Claim Status	05/05/2014 3:48:00PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	9452367	Employee
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Topic: return call to ee  
DBM ADVISED EE CLAIM WILL BE REVIEWED TOMORROW

E-mail from Member	05/05/2014 1:37:33PM	ANASTASIA SNOOK	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: EE req status  
Will there be a decision tomorrow as promised?

Claim Status	04/28/2014 3:42:11PM	AKINKAWON TURNER	STD / LOA Benefit Manager	9452367	Employee
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Topic: rtc to ee  
lvmm to advise claim under review ltd dbm will respond once an update is available

E-mail from Member	04/28/2014 1:25:03PM	ANASTASIA SNOOK	CUSTOMER SRVC REPRESENTATIVE	9452367	Employee
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Topic: EE req status  
I see my claims representative has changed, is there any update on my claim?

Claim Status	04/03/2014 9:44:01AM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Provider
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Topic: f/u with Dr. Green/PM&R  
Sent a request to Dr. Green for APS and evaluation dated 03/25/2014

Claim Status	03/27/2014 4:13:02PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: status  
outreach to ee to advise claim approved through eob and peer review requested  
ee is willing to assist if there are any issues with reaching dr

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

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## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	03/20/2014 1:50:09PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee

Topic: rtc to dbm

helen rtc to dbm to advise ee has sx scheduled for 4/18/2014 for knee  
ee 6weeks out from shoulder sx however still doing pt 3x's a week for strength  
no f/u visit due to ee coming in for sx 4/18/2014

Claim Status	03/20/2014 1:47:08PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: pt notes

dbm spoke with phone rep requested pt notes to be sent for shoulder most recent  
rep indicated would send for review

Claim Status	03/19/2014 9:51:44AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: medical information

outreach to ee regarding pt notes, and notes regarding ee's back issues with dr cote  
ee indicated is going to pt today will have pw faxed for review, and will go directly to dr cote's office for pw to be sent regarding ee's back

Claim Status	03/18/2014 3:41:30PM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Employee
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Topic: knee surgery

Claimant informed me that she will have knee surgery April 18, 2014 by Dr. Renfro. Still pending records from Dr. Cote/back surgeon. Will be evaluated by PM&R 04/02/2014.

Claim Status	03/18/2014 3:08:41PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: JAMES RENFRO Orthopedic Surgery 12/13/2013 615-834-4482

outreach to dr renfro to confirm sx date  
lvmm for helen bottleworth to rtc with ee's nov date and if ee scheduled for knee sx

Payment Inquiry	03/13/2014 9:00:42AM	NADINE STOLARSKI	SR CUSTOMER SERVICE REP	8893435	Employee
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Topic: ee called about his pay

ee was advised we atp. claim approved to 3/11/14. meds rec to review. ee to fu with his er

Claim Status	03/07/2014 9:27:31AM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Employee
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Topic: status

Claimant has advised me via e-mail that Dr. Cote does not do disability paperwork but he will have the medical records faxed to me. He is going to pain mgt today and I requested he sent the contact information for pain mgt physician. I will advise STD.

Claim Status	03/07/2014 2:05:41AM		Not On File	8893435	Employee
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Topic: STD - RTW Autocall Results

First Name:ARTHUR Last Name:DAVIS Claim ID:8893435 Appr Thru Date:03/11/2014 Call Date/Time:2014-03-06 13:09:39 Call Attempt:1 Call Status:Inbound:  
Non-Responsive - Recipient hung up in header or failed to give a response to YN Authentication & system disconnected call Call Recipient Status: QUESTION: Are you RTW? QUESTION: May we transfer you?

Claim Status	03/07/2014 2:05:41AM		Not On File	8893435	Employee
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Topic: STD - RTW Autocall Results

First Name:ARTHUR Last Name:DAVIS Claim ID:8893435 Appr Thru Date:03/11/2014 Call Date/Time:2014-03-06 13:32:21 Call Attempt:1 Call Status:Inbound:  
Authenticated - Recipient Reached First Body Component Call Recipient Status: QUESTION: Are you RTW?NO QUESTION: May we transfer you?YES

Claim Status	03/07/2014 2:05:40AM		Not On File	8893435	Employee
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Topic: STD - RTW Autocall Results

First Name:ARTHUR Last Name:DAVIS Claim ID:8893435 Appr Thru Date:03/11/2014 Call Date/Time:2014-03-06 11:46:59 Call Attempt:1 Call  
Status:Authenticated - Recipient Reached First Body Component Call Recipient Status:OUTBOUND COMPLETE QUESTION: Are you RTW?NO QUESTION: May we transfer you?

Claim Status	03/06/2014 1:39:10PM	LINDSAY LAMB	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: rtw auto call

TCF EE he got the RTW auto call EE is not rtw on 3/12 he will need an extension, he stated that the AP should be sending updated medical info soon.

Claim Status	02/27/2014 3:05:52PM	PAUL FRUGE	Intake Representative	9452367	Employee
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Topic: TCF EE to see if tax form rec, CSR advised rec 2/26.'

# Central Note System - View All Report

[Click Here To Access The Excel Export View](#)

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	02/21/2014 9:00:40AM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Employee

Topic: W4-S

I spoke to claimant and ask him to complete a W4-s. I provided him with the IRS website or the aetna disability website.

Was paperwork received	02/20/2014 1:46:35PM	JEREMY MOORE-WILLIAMS	customer service rep	9452367	Employee
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Topic: ee cking on p/w recieved

csr adv p/w recieved 02/20for reviewing by ltdm

Claim Status	02/18/2014 10:44:13AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: extended

outreach to ee to advise claim extended through nov 3/11/2014 need meds, pt notes. office visit notes to be sent for review lvmm

Claim Status	02/14/2014 2:18:45PM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Employee
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Topic: LTD Claimant Interview

Initial Documentation of telephonic interview: Claimant Name: Arthur Davis, Claim 9452367, Dell Inc. -----

----- DO YOU HAVE AETNA HEALTH INSURANCE/ who is your carrier? Currently I have Aetna COBRA. HISTORY / ONSET OF CONDITION: If it began prior to the date of disability, or is long standing, what changed to cause them to stop working? My shoulder tendons fell off both my right and left shoulder. I was just mowing the lawn and lost full use of my arms. Unfortunately I was struck from behind and now have a Herniated Disc in my back which is causing severe pain along with my shoulder difficulties. What is your current medical treatment plan? I have therapy for my left shoulder two days a week. No therapy scheduled for right shoulder yet. Operation was on January 31st 2014. Is condition related to work in any way? Did you file a Workers Compensation claim? Name of company and claim adjuster? No, not work related. Do you have an attorney? Name, address, phone # David Clarke of Murfreesboro TN is representing me concerning the back injury. (615) 796-6299 111 North Maple Street, Murfreesboro, TN 37130 Did you have a non-work related injury or a MVA (Motor Vehicle Accident)? If so, how did the accident occur? When was the accident? Where? City and State? Any legal action pending due to original injury? Was a police report filed? If so, where was it filed? The back injury was a motor vehicle accident occurred September 27, 2014. Police report was filed with Murfreesboro TN police department. David Clarke is handling the case. Restrictions & Limitations? what did your physician advise you to avoid or that you should limit? I have a planned exercise program for my shoulders and back, I just do my therapy. My back problems have limited my activity as well. Height and weight: 6 feet 236lbs Name of all Medical Providers, provide phone and fax number.- How long have you been treating with them? October of 2014 to present. Dr. James Renfro of Premier Orthopaedics is treating me strictly for my shoulders. Dr. Christopher Kaufman was treating me for my back. November of 2014 to January 2015. 394 Harding Place. Nashville, TN 37211. Dr Nicholas Cote has taken over current back treatment. I attend therapy 3 times a week for my back. 1272Garrison Drive, Murfreesboro, TN 37129 Did you discuss your job duties with your provider? Yes Prescription medications/ what conditions are they prescribed for? I take Celebrex for my back and I have a number of painkillers for my shoulders and back when necessary. Describe a Typical Day/ ADLs: Back therapy at 9 or 9:30 until 10:30AM. Shoulder therapy at 11AM until 12PM. I come back home. Any help with household duties? Or shopping? Driving? Yard work? Child or elder care? My son helps with any large item shopping. I can do small item shopping. I don't drive a lot, it hurts my back and my shoulders. I hate to admit I have not cleaned my apartment since second surgery. My son lives with his mother, I am responsible for child support. Volunteer work? where, how often, how many hours? NA RTW (return to work) Status: Projected Date? What are your plans for work? (or retirement?) Dr. James Renfro is predicting a March return date for shoulders. No ETA concerning my back, very difficult typing this email, both shoulders and back pain. Duties and Requirements of your Occupation: At least 8-10 hours a day sitting at desk making calls and typing. Job Status with ER? Are they holding your job? When did you last speak with your supervisor? Dell have offered me a severance package, I have accepted. Will they allow part-time or light duty work or provide any accommodations? Would you like assistance with RTW? NA Earnings: Your employer indicates your earnings as: \$99,101.30/year. Do you agree? Yes Retirem

Claim Status	02/14/2014 10:08:42AM	MARIBEL AMOR	Senior LTD Claim Analyst	9452367	Employee
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Topic: tPC

Left vmm for claimant to call me back.

Claim Status	02/14/2014 9:27:09AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: ee's pay

ee called to indicate that still short on his pay, ee feels that he is due 3000.00 additional dollars from er dbm advised that will see if payroll rep can contact ee to reconcile payments

Claim Status	02/14/2014 9:17:31AM	DEBBIE TAYLOR	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: Status of pmnts

tpc from ee for status of pmnts, CSR advised ER is ATP, EE wants to recd pmnt thru disability, call transd to DBM

Claim Status	02/13/2014 10:08:35AM	DONNA CHAPMAN	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: was pw received

tcf ee

confirmed pw was received

advised ee payments are handle through er

confirmed claim approval dates

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

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## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	02/11/2014 2:04:04AM		Not On File	8893435	Employee

Topic: STD - RTW Autocall Results

First Name:ARTHUR Last Name:DAVIS Claim ID:8893435 Appr Thru Date:02/13/2014 Call Date/Time:2014-02-10 11:18:04 Call Attempt:1 Call Status:Answering Machine - Answering Machine Message Left Call Recipient Status:OUTBOUND IN-PROGRESS QUESTION: Are you RTW? QUESTION: May we transfer you?

Claim Status	02/11/2014 2:04:04AM		Not On File	8893435	Employee
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Topic: STD - RTW Autocall Results

First Name:ARTHUR Last Name:DAVIS Claim ID:8893435 Appr Thru Date:02/13/2014 Call Date/Time:2014-02-10 11:26:15 Call Attempt:1 Call Status:Inbound: Authenticated - Recipient Reached First Body Component Call Recipient Status: QUESTION: Are you RTW?NO QUESTION: May we transfer you?YES

Claim Status	02/07/2014 9:50:16AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: status

f/u with ee regarding approved extension, also need for meds from post-op visit for review

ee right hand dominate sx performed on 1/31/14

ee with therapy still on left shoulder attending today

and also therapy for back herniated disc

ee very miserable unable to sleep in his bed sleeps in a recliner chair was sleeping on a bean bag takes oxycodone for pain and to sleep at night

ee referred to eap for concerns with constant pain and also feeling miserable

Claim Status	02/04/2014 4:32:51PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: rtc to dbm

pat indicated that ee has f/u appt on 2/11/2014

fd rtw 6 months light duty rtw 1 month based on sx

dbm advised ee pdl is sedentary and will send jd to dr for review

Claim Status	02/04/2014 4:23:03PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: JAMES RENFRO Orthopedic Surgery 12/13/2013 615-834-4482

outreach to dr renfro to confirm f/u visit date, prtw date

lvmm for a rtc from helen

to rtc with f/u visit date and also rtw date

Claim Status	01/30/2014 2:54:38PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: update

outreach to ee to advise claim updated, also will confirm sx and update claim

ee understood

Returning Call	01/24/2014 1:12:56PM	SHAWNDR LEE	LTD BENEFIT MANAGER	8893435	Employee
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Topic: DBM rtc to EE

DBM rtc to EE regarding claim status. EE informed that EE would be schedule for sx on 01/31/2014. DBM inquired when was the last OVN with the provider. EE informed that he was last seen on 01/09/2014. DBM informed that she will request OVN from 01/09/2014 to be submitted to Aetna for review. EE then inquired when will his ER know that he should be paid thru 01/12/2014. DBM informed that Er was notified of extension on 01/09/2014. DBM advised EE to f/u with ER regarding payment.

Claim Status	01/24/2014 9:24:33AM	DOUGLAS HEYER	SR CUSTOMER SERVICE REP	8893435	Employee
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Topic: update

ee calling has not RTW is still out and will have SX on 1/31/14 no plans to RTW between now and then advised I would let the DBM know ee states medical we havealready states he would not RTW until 1/31/14 but now not even rtw then will have SX that day

E-mail from Member	01/19/2014 9:27:41PM	THEODORA WILLIAMS	CSR	8893435	Employee
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Topic: ee will need additional time oow

Email from member

Good afternoon I have scheduled surgery for my right shoulder for January 31st. Unfortunately my right shoulder has deteriorated quickly, the tear has gotten worst and I will not be returning to work until second shoulder has recovered.

theodora williams csr

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
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Claim Status	01/17/2014 10:12:20AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: reviewed  
reviewed

Claim Status	01/17/2014 10:10:46AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: rtc to ee regarding pay  
lvmm for a rtc with contact performing surgery, also to advise looking into pay issue

Claim Status	01/17/2014 9:31:23AM	MOHINEE VELIAN	USTOMER SERVICE REPRESENTATIVE	8893435	Employee
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Topic: I INFORM EE CLAIM IS APPROVED FROM 10/09-01/12 AND HIS ER IS PAYING, HE IS REQUESTING A CALL BACK  
I INFORM EE CLAIM IS APPROVED FROM 10/09-01/12 AND HIS ER IS PAYING , HE IS REQUESTING A CALL BACK

E-mail from Member	01/10/2014 8:01:18AM	THEODORA WILLIAMS	CSR	8893435	Employee
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Topic: sx date  
Email from member

I was seen by my surgeon this morning and have scheduled surgery for my right shoulder to repair the Torn Rotator Cuff in that shoulder. Surgery is scheduled for January 31st at 1PM. I was advised I should wait for second surgery to give my left arm more time to heal but I feel pressured to proceed.

Claim Status	01/03/2014 12:14:19PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: rtc to ee  
outreach to ee to advise requested pt notes, rom values, treatment plan, rtw date  
dr only sent in office visit note from 12/13

no meds to support an extension of std benefits

ee says fixing left shoulder, and right shoulder is getting worse  
ee doing pt two times a week ee can't lift and right arm is worse

Claim Status	01/03/2014 10:03:29AM	JACOB PETERSON	SR CUSTOMER SERVICE REP	8893435	Employee
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Topic: TCF EE for follow up on the claim for processing of benefit  
TCF EE for follow up on the claim for processing of benefit  
ADvised on the claim for processing of pprwk from 12/18/13  
ADvised still in review with the claim and not sure why not processed  
Reached out to DBM for update in the claim  
DBM unavial  
EE request c.b

Claim Status	12/13/2013 1:07:57PM	DOMINICA TAYLOR	OR CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: claim  
tcf ee re claim dell will be doing layoffs. adv as long as ee is still disabled ee can be out on std until 040614.

Claim Status	12/05/2013 2:27:09PM	DOMINICA TAYLOR	OR CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: fax number  
tcf ee re fax number  
adv to put claim number at top of form  
adv fax number 866-667-1987

Claim Status	12/05/2013 11:08:34AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: reviewed  
update

Claim Status	12/05/2013 11:02:21AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: rtc to dbm  
sue indicated ee's nov is on 12/13/2013 for review

Returning Call	12/05/2013 11:01:53AM	ANNIE SANTOS	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: update  
TCF EE says his NOV is on 12/13/13 w/Dr.Renfro and will be faxing in ROI form.

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	12/05/2013 10:37:08AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee

Topic: f/u with ee  
outreach to ee to advise trying to confirm nov date, also if ee can provide release of information request with provider  
so we can update claim

lvmm for a rtc with nov date

Claim Status	12/05/2013 10:22:28AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: JAMES RENFRO Orthopedic Surgery 615-834-4482  
outreach to dr renfro

spoke with sue in scheduling would not release the nov date due to hippa law

Claim Status	12/02/2013 1:09:41PM	RHONDA SICIARIDIS	STD Claim Analyst	8893435	Employee
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Topic: pending claim recert  
RECEIVED CALL FROM EE. VERIFIED CLINICALS RECEIVED 11/21/13. EXPLAINED REVIEW/RECERT PROCESS. ADVISED DBM WILL CONTACT ONCE REVIEW IS COMPLETE.

Claim Status	11/26/2013 1:37:54PM	LORI BRADSHAW	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: claim status  
tcf ee wanted to know claim status  
csr stated that medialinfo is in review that we rec'vd on 11/21  
ee understood

Claim Status	11/20/2013 10:00:50AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: reviewed  
will contact ee once update is available

Claim Status	11/20/2013 9:16:54AM	KARINA TABORDA	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: tcf ee  
ee wanted to know why claim still states he will rtw on 11/25. advs ee that claim still in review. ee asked for dbm to contact him when review complete

Payment Inquiry	11/01/2013 9:19:01AM	MARY BELL-THOMPSON	Sr Customer Service Rep	8893435	Employee
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Topic: Payment  
tcf ee called to confirm payment dates, ee advised claim is ATP W/ CAL. EE was referred back to his employers to confirm payment dates.

Payment Inquiry	10/24/2013 4:51:50PM	ERIC PECKHAM	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: EE cld in  
TCF EE inq abt pymnt info if mailed or dir dep. Adv pymts handled ER adv to verify w/ER to confirm. Benefit Schedule:WEEKLY. EE inq if get right shoulder done  
would claim be approved. Adv claim would pend based ff When Sx performed for right side.

Claim Status	10/17/2013 5:44:31PM	KELINDA WARLING	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: claim status  
tcf ee stated he made call this morning and also sent email adv claim was approved 10-9-13 thru 11-24-13 adv fmla was approved also adv ee close to rtw will f/u  
and if ee needs to ext will req ovn adv atp/calcs adv 7 day e/p

Claim Status	10/17/2013 10:55:10AM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: reviewed  
reviewed

Claim Status	10/16/2013 11:23:12AM	JOHN WORLEY	CUSTOMER SRVC REPRESENTATIVE	8893435	Employee
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Topic: tcf ee  
tcf ee - received aps and additional notes , adv is under rev



# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	10/15/2013 2:36:12PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee

Topic: rtc regarding dates  
ee indicated fda 10/9 as ee ws unable to work was in pain on narcotics had sx on 10/11 two rotator cuff tears which required sx, dbm advised ee need meds from dr to support days prior as only sx information and mri however nothing indicating ee unable to work prior

ee understood

Returning Call	10/15/2013 2:19:32PM	BRENDA WATERS	csr	8893435	Employee
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Topic: ee rtc  
ee rtc  
ee was giving dates that he was out in sept. asking dont these days count..  
csr explained that cm needed to know the fda for the claim right now.. ee stated 10 09  
cm will call ee back to clear this up

Claim Status	10/15/2013 1:57:39PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: clarify dates oow  
lvmm to advise fda/dos would be 10/11 days oow prior are non disability days  
dbm will proceed with update and advise ee

Claim Status	10/15/2013 1:23:58PM	AKINKAWON TURNER	STD / LOA Benefit Manager	8893435	Employee
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Topic: fda 10/11 sx date vacation days prior  
review confirm and update

Claim Status	10/14/2013 12:58:05PM	LESLEY DUTIL	Customer Srvc Representative	8893435	Employee
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Topic: rtcf ee  
rtcf ee, I asked ee to confirm following:  
LDW 10/8  
FDA 10/9  
SX date 10/11  
ee took vacation days for 10/9 & 10/10  
NOV 10/18  
PRTW 4 weeks or longer  
SX TYPE rotator cuff  
HOSPITALIZATION DATES admitted 10/11 discharged 10/11  
ee will lfup with apo for aps to be returned

Claim Management Process	10/11/2013 4:07:58PM	SHATOYA ROBEY	Disability Benefits Manager	8893435	Employee
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Topic: INITIAL EE CONTACT  
IA CALLED EE **REDACTED** AND LVM FOR EE TO RTC TO AETNA  
SR 10/11/2013 407PM  
NEED TO CONFIRM:  
FDA  
LDW  
NOV  
PRTW  
DX  
SX DATE(IF APPLICABLE)  
SX TYPE(IF APPLICABLE)  
HOSPITALIZATION DATES(IF APPLICABLE)  
NEED TO ADVISE EE WILL BE PLACED ON PENDING LEAVE AND WILL NOT BE PAID UNTIL STD HAS BEEN APPROVED. ALSO ADVISE EE OF 7 DAY WP AND ADVISED EE CAN USE PBA/VAC TO COVER TIME OOW UNTIL STD IS APPROVED, AND IF STD IS APPROVED EE WILL BE REIMBURSED EE'S PBA/VACATION EXCEPT TIME USED FOR WP

Forms	10/10/2013 4:41:46PM	MAHADI THASSIM	CUSTOMER SRVC REPRESENTATIVE	8893560	Employee
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Topic: ee in received std/fmla package with wrong claim #  
adv portal to download correct forms



# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Contact Notes History

View : EMPLOYEE

Contact Filter : ALL

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	CLAIMID	SOURCE
Claim Status	10/10/2013 11:22:10AM	CHERYL RUTH	CUSTOMER SRVC REPRESENTATIVE	Employee	Employee

Topic: ee transferred to make a STD claim

EE transferred to make a STD claim, he thought that was what he made, but he told rep to make it a intermittent claim, he needs continuous claim .

Supervisor: Susan Park

Phone: 512-513-2701

Display: 518-451-3000 x 78738

\*Actual FDA is 10/08/2013.

Actual LDW 10/07/2013

Already selected for an FMLA claim so I selected 10/2/2013 and using 10/1/2013 as LDW \*\*EE on more than 2 medications a day

Claim Status	10/10/2013 10:55:36AM	TERESA CRESPO	STD / LOA BENEFIT MANAGER	8864540	Other
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Topic: ee requesting add std to loa

acknwldg, open a std claim

Claim Status	10/10/2013 10:53:51AM	ANASTASIA SNOOK	CUSTOMER SRVC REPRESENTATIVE	8864540	Employee
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Topic: EE SX date

TCF EE to advise his SX is 10/11. EE advised he has not recv'd anything in the mail, CSR advised need HCPC to approve the claim. EE advised need STD claim opened, thought did yesterday. CSR advised not STD open, only FMLA intermittent. CSR transferred EE to Intake to open STD claim.

Claim Status	10/08/2013 4:17:12PM	SHARLYNN DARRIS	CUSTOMER SRVC REPRESENTATIVE	8864540	Employee
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Topic: ee requesting add std to loa

ee is having surgery for same condition as existing intermitten loa claim.

please change status from intermitten to continuoius and add std

FDA: 10/9/

LDW: 10/8

\*\*GAP: intermitten loa claim 10/9- 11/11

RTW: 4 weeks 11/11/13, then start therapy

Hospital: Premier Orthopaedics @ 615-332-3600

Dr: james renfro @ 394 harding place nashville tenn 37211

Claim Status	10/08/2013 4:07:39PM	BAMBI JEREMICZ	CUSTOMER SRVC REPRESENTATIVE	8864540	Employee
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Topic: New Claim

New Claim Transferred ee to Intake.

Claim Status	10/07/2013 5:12:20PM	BAMBI JEREMICZ	CUSTOMER SRVC REPRESENTATIVE	8864540	Employee
--------------	----------------------	----------------	------------------------------	---------	----------

Topic: EE calling in surgery information

EE called to advise he will be having out patient surgery on 10/11/2013 at Premier Orthopedics. Advise ee to call and confirm on 10/10/2013 that he is still having his surgery so we can follow up for any additional information that may be needed. EE also called in days out from 10/8/2013 ,10/09/2013,10/10/2013 and 10/11/2013 all full days. Transaction Number 8877357

Claim Status	10/07/2013 12:05:17PM	TERESA CRESPO	STD / LOA BENEFIT MANAGER	8864540	Other
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Topic: EE REPORTED 09/09, 09/19, 09/27 AND 10/07 FROM 07AM-09AM AND 10/07 FROM 02PM-04PM

acknwldg

Claim Status	10/04/2013 5:31:11PM	MOHINEE VELIAN	USTOMER SERVICE REPRESENTATIVE	8864540	Employee
--------------	----------------------	----------------	--------------------------------	---------	----------

Topic: EE REPORTED 09/09 , 09/19, 09/27 AND 10/07 FROM 07AM-09AM AND 10/07 FROM 02PM-04PM

EE REPORTED 09/09. 09/19 AND 09/27 AND 10/07 FROM 07AM-09AM AND 10/07 FROM 2PM-04PM

(Less Info)

Client Name: Dell Inc

Claim Status: Closed

Date of Birth: REDACTED

Contract Situs: TX

Preferred Contact#: REDACTED

Current Analytics:

Work Capacity Level: No Current Work Capacity

Claim Owner: LEE, SHAWNDR

Age: 52

Tier: Tier 3

Phone (Mobile)

End Of Benefit(EOB): 10/31/2028

3

12 Month Duration

4

18 Month Duration

5

24+ Month Duration

7

IHD Consent Effective: N/A

OP Balance: N/A

Gender: Male

Estimated RTW:

Disability Date: 10/09/2013

Age at DCI: 50

Providers

Benefit Engine

PeopleSoft

Rehab Vendors

Alerts

Contacts

Summary & Action Plan

Medical

Vocational

Financial

▲ Most Recent Financial Information

Benefit Salary(\$)	Benefit %	Gross Benefit(\$)	Payroll Days	Benefit Schedule	Max Benefit(\$)	Min Benefit	Alt Payee
\$5,284.3442	60.0000	\$3,170.6100	30ACTUAL	MONTHLY	\$10,000.000		
<a href="#">Financial Authorization</a> (02/20/2014)	<a href="#">Followup SSDI Review Task</a> (02/03/2015)	Garnishments (Not Available)	Mature Claim Referral (Not Available)	<a href="#">Other Income Questionnaire</a> (02/20/2014)	<a href="#">Reimbursement Agreement</a> (02/20/2014)	<a href="#">Tax Forms</a> (02/27/2014)	

Current Offsets

Current Deductions

No Offsets found

Manage Notes: 

ADD NEW

Financial Notes History

Expand All Details

Note Type Filter All

Show All Notes

Note Type	Last Update Date	Creator	Title
▼ Offset	9/8/2015 12:53:59 PM	LAURIE KATON	FINANCIAL BENEFIT MANAGER
Topic: Rawlings - RA, contract and payment history and recoverable amounts sent			
▼ Calculation	5/23/2014 3:36:38 PM	AMANDA FERRANTE	LTD BENEFIT MANAGER
Topic: Financial Worknote			
▼ Calculation	5/23/2014 3:29:34 PM	AMANDA FERRANTE	LTD BENEFIT MANAGER
Topic: Financial Worknote			

▼	Calculation	▼	5/7/2014 2:02:22 PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST
Topic:	Financial Worknote				
▼	Calculation	▼	3/20/2014 3:03:01 PM	AMANDA FERRANTE	LTD BENEFIT MANAGER
Topic:	Financial Worknote				
▼	Offset	▼	3/20/2014 12:16:47 PM	LAURIE KATON	FINANCIAL BENEFIT MANAGER
Topic:	Praxis Referral - sent to Praxis regarding MVA				
▼	Calculation	▼	3/19/2014 12:16:47 PM	MARIBEL AMOR	Senior LTD Claim Analyst
Topic:	Financial Worknote				

(Less Info)

Client Name: Dell Inc

Work Capacity Level: No Current Work Capacity

IHD Consent Effective: N/A

Claim Status: Closed

Claim Owner: LEE, SHAWNDR

OP Balance: N/A

Date of Birth: REDACTED

Age: 52

Gender: Male

Contract Situs: TX

Tier: Tier 3

Estimated RTW:

Preferred Contact#: REDACTED

Phone (Mobile)

End Of Benefit(EOB): 10/31/2028

Disability Date: 10/09/2013

Age at DCI: 50

Current Analytics:

6 Month Duration 3

12 Month Duration 4

18 Month Duration 5

24+ Month Duration 7

Providers

Benefit Engine

PeopleSoft

Rehab Vendors

Alerts

Contacts

Summary & Action Plan

Medical

Vocational

Financial

▲ Most Recent Financial Information

Benefit Salary(\$)	Benefit %	Gross Benefit(\$)	Payroll Days	Benefit Schedule	Max Benefit(\$)	Min Benefit	Alt Payee
\$5,284.3442	60.0000	\$3,170.6100	30ACTUAL	MONTHLY	\$10,000.000		

[Financial Authorization](#)  
(02/20/2014)

[Followup SSDI Review Task](#)  
(02/03/2015)

Garnishments  
(Not Available)

Mature Claim Referral  
(Not Available)

[Other Income Questionnaire](#)  
(02/20/2014)

[Reimbursement Agreement](#)  
(02/20/2014)

[Tax Forms](#)  
(02/27/2014)

Current Offsets

Current Deductions

No Deductions found

Manage Notes:

ADD NEW

Financial Notes History

Expand All Details

Note Type FilterAllShowAllNotes

Note Type	Last Update Date	Creator	Title
▼ Offset	9/8/2015 12:53:59 PM	LAURIE KATON	FINANCIAL BENEFIT MANAGER
Topic: Rawlings - RA, contract and payment history and recoverable amounts sent			
▼ Calculation	5/23/2014 3:36:38 PM	AMANDA FERRANTE	LTD BENEFIT MANAGER
Topic: Financial Worknote			
▼ Calculation	5/23/2014 3:29:34 PM	AMANDA FERRANTE	LTD BENEFIT MANAGER
Topic: Financial Worknote			

▼	Calculation	▼	5/7/2014 2:02:22 PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST
Topic:	Financial Worknote				
▼	Calculation	▼	3/20/2014 3:03:01 PM	AMANDA FERRANTE	LTD BENEFIT MANAGER
Topic:	Financial Worknote				
▼	Offset	▼	3/20/2014 12:16:47 PM	LAURIE KATON	FINANCIAL BENEFIT MANAGER
Topic:	Praxis Referral - sent to Praxis regarding MVA				
▼	Calculation	▼	3/19/2014 12:16:47 PM	MARIBEL AMOR	Senior LTD Claim Analyst
Topic:	Financial Worknote				

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Financial Notes History

Note Type Filter : ALL

NOTE TYPE	LAST UPDATE DATE	CREATOR	TITLE
Offset	09/08/2015 12:53:59PM	LAURIE KATON	FINANCIAL BENEFIT MANAGER

Topic: Rawlings - RA, contract and payment history and recoverable amounts sent  
Email from Angela Scheirmann

.  
LTD period: 04-07-14 thru 01-11-15  
LTD amount paid: \$29063.93  
LTD MMB amount: \$2906.39  
LTD recoverable amount: \$26157.54  
LTD outstanding overpayment: n/a

Calculation	05/23/2014 3:36:38PM	AMANDA FERRANTE	LTD BENEFIT MANAGER
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Topic: Financial Worknote

Notes : Praxis investigation revealed no viable opportunities for recovery & no TP language in contract. They have closed their file. , Plan of Action :

Calculation	05/23/2014 3:29:34PM	AMANDA FERRANTE	LTD BENEFIT MANAGER
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Topic: Financial Worknote

Notes : Praxis Disability Group has identified a TPL/Subrogation opportunity and is pursuing same. Please contact Alison Stackpole at 765.216.0240 or alison.stackpole@praxisconsulting.com with any questions. , Plan of Action :

Calculation	05/07/2014 2:02:22PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST
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Topic: Financial Worknote

Notes : LTD Benefit Level Authority Review Task Template \*\*\*\*\* EE CONTRIB: 0% -  
N/A DLW: 10/8/2013 DCI: 10/9/2013 ANY RTW DURING EP: N/A LTD BNFT EFF ANY SUCCESSIVE AFTER EP: N/A MRBE: \$5,284.34 BNFT: 60% IMAX:  
\$3,170.61 ER MAX: N/A MIN BNFT: \$100 OR 10% WHICHEVER IS GREATER OIQ ON FILE: ON FILE RA ON FILE: ON FILE OFFSET: STATE DISABILITY (NY, NJ,  
CA, HI, PR, RI) STATE TAX (NC, VA, IL, OH (work Portsmouth/Columbus)?: (ATLAS only) TAX: (ATLAS only) DEDUCTION: N/A REMARKS: TOTAL INITIAL  
PAYMENT 4/7/2014- 4/30/2014 GROSS/OFFSET/NET BNFT \$2,536.49/\$00.00/\$2,536.49 5/1/2014- ON-GOING GROSS/OFFSET/NET BNFT \$3,170.61/\$00.00/  
\$3,170.61 , Plan of Action : Section B Have you reviewed the claim and agree with the benefit calculation being requested above? Yes \_\_\_x\_\_\_ No \_\_\_ If No is  
selected, please document reason not approving and recommendations/instructions:

Calculation	03/20/2014 3:03:01PM	AMANDA FERRANTE	LTD BENEFIT MANAGER
-------------	----------------------	-----------------	---------------------

Topic: Financial Worknote

Notes : Aetna has referred this claim to Praxis for investigation of WC/TPL. Please contact Alison Stackpole at 765.216.0240 or alison.stackpole@praxisconsulting.com if you have any questions. Praxis has accepted the referral and is pursuing on behalf of Aetna. , Plan of Action :

Offset	03/20/2014 12:16:47PM	LAURIE KATON	FINANCIAL BENEFIT MANAGER
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Topic: Praxis Referral - sent to Praxis regarding MVA  
Rec'd Praxis referral from Maribel Amor regarding MVA.

.  
referral sent to Praxis along with contract

Calculation	03/19/2014 12:16:47PM	MARIBEL AMOR	Senior LTD Claim Analyst
-------------	-----------------------	--------------	--------------------------

Topic: Financial Worknote

Notes : Received payroll information from Dell. Base salary: \$44,388.49 Commissions: \$19,023.64 Income: \$62,412.13 monthly salary: \$5,284.34 x 60%=  
\$3,179.61 Once, I receive the records from Dr. Cote to address the back issue and the PT notes I will be able to render a determination. , Plan of Action :

(Less Info)

Client Name: Dell Inc

Claim Status: Closed

Date of Birth: REDACTED

Contract Situs: TX

Preferred Contact#: REDACTED

Current Analytics:

Work Capacity Level: No Current Work Capacity

Claim Owner: LEE, SHAWNDR

Age: 52

Tier: Tier 3

Phone (Mobile)

12 Month Duration 3

18 Month Duration 4

24+ Month Duration 7

IHD Consent Effective: N/A

OP Balance: N/A

Gender: Male

Estimated RTW:

Disability Date: 10/09/2013

Age at DCI: 50

Providers

Benefit Engine

PeopleSoft

Rehab Vendors

Alerts

Contacts

Summary & Action Plan

Medical

Vocational

Financial

▲ Most Recent Claim Information

Primary ICD Code Type	Primary ICD Code	Primary ICD Code Description	Primary ICD Code Effective Date
ICD9	782.0	DISTURBANCE OF SKIN SENSATION	07/14/2014

BHU Review  
(Not Available)

[Clinical Review](#)  
(05/06/2014)

[Medical Authorization Form](#)  
(02/24/2015)

[Peer Review](#)  
(04/13/2015)

Physician Review  
(Not Available)

☒ Clinical Trigger

Additional ICD Information

Procedure Information

ICD History

ICD Code Type	ICD Code	ICD Description
ICD9	724.2	LUMBAGO
ICD9	722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
ICD9	724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS, UNSPECIFIED
ICD9	355.71	CAUSALGIA OF LOWER LIMB

Manage Notes:

ADD NEW

Medical Notes History

Expand All Details

Show 10 Notes

No History found

(Less Info)

Client Name: Dell Inc

Claim Status: Closed

Date of Birth: REDACTED

Contract Situs: TX

Preferred Contact#: REDACTED

Current Analytics:

Work Capacity Level: No Current Work Capacity

Claim Owner: LEE, SHAWNDR

Age: 52

Tier: Tier 3

Phone (Mobile)

End Of Benefit(EOB): 10/31/2028

6 Month Duration 3

12 Month Duration 4

18 Month Duration 5

24+ Month Duration 7

IHD Consent Effective: N/A

OP Balance: N/A

Gender: Male

Estimated RTW:

Disability Date: 10/09/2013

Providers

Benefit Engine

PeopleSoft

Rehab Vendors

Age at DCI: 50

Alerts

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Summary & Action Plan

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Financial

▲ Most Recent Claim Information

Primary ICD Code Type	Primary ICD Code	Primary ICD Code Description	Primary ICD Code Effective Date
ICD9	782.0	DISTURBANCE OF SKIN SENSATION	07/14/2014

BHU Review  
(Not Available)

[Clinical Review](#)  
(05/06/2014)

[Medical Authorization Form](#)  
(02/24/2015)

[Peer Review](#)  
(04/13/2015)

Physician Review  
(Not Available)

☒ Clinical Trigger

Additional ICD Information

Procedure Information

ICD History

CPT Code	CPT Description	MDA	Procedure Date
29827	ARTHROSCOPY, SHOULDER, SURGICAL; W/ROTATOR CUFF REPAIR		10/11/2013
29826	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION, SUBACROMIAL SPACE W/PARTIAL ACROMIOPLASTY		10/11/2013
29822	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED		10/11/2013
23420	RECONSTRUCTION, COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)		01/31/2014
29822	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED		01/31/2014

Manage Notes: 

ADD NEW

Medical Notes History

Expand All Details

Show 10 Notes

No History found



(Less Info)

Client Name: Dell Inc

Claim Status: Closed

Date of Birth: REDACTED

Contract Situs: TX

Preferred Contact#: REDACTED

Current Analytics:

Work Capacity Level: No Current Work Capacity

Claim Owner: LEE, SHAWNDR

Age: 52

Tier: Tier 3

Phone (Mobile)

6 Month Duration 3

12 Month Duration 4

18 Month Duration 5

24+ Month Duration 7

IHD Consent Effective: N/A

OP Balance: N/A

Gender: Male

Estimated RTW:

Disability Date: 10/09/2013

Providers

Benefit Engine

PeopleSoft

Rehab Vendors

Age at DCI: 50

Alerts

Contacts

Summary & Action Plan

Medical

Vocational

Financial

▲ Most Recent Claim Information

Primary ICD Code Type	Primary ICD Code	Primary ICD Code Description	Primary ICD Code Effective Date
ICD9	782.0	DISTURBANCE OF SKIN SENSATION	07/14/2014

BHU Review (Not Available)

[Clinical Review](#) (05/06/2014)

[Medical Authorization Form](#) (02/24/2015)

[Peer Review](#) (04/13/2015)

Physician Review (Not Available)

☒ Clinical Trigger

Additional ICD Information

Procedure Information

ICD History

ICD Code Type	ICD Code	ICD Description	Effective Date
ICD9	840.4	ROTATOR CUFF (CAPSULE) SPRAIN	10/09/2013

Manage Notes: 

ADD NEW

Medical Notes History

Expand All Details

No History found

Show 10 Notes

(Less Info)

Client Name: Dell Inc

Claim Status: Closed

Date of Birth: REDACTED

Contract Situs: TX

Preferred Contact#: REDACTED

Current Analytics:

Work Capacity Level: No Current Work Capacity

Claim Owner: LEE, SHAWNDR

Age: 52

Tier: Tier 3

Phone (Mobile)

End Of Benefit(EOB): 10/31/2028

6 Month Duration 3

12 Month Duration 4

18 Month Duration 5

24+ Month Duration 7

IHD Consent Effective: N/A

OP Balance: N/A

Gender: Male

Estimated RTW:

Disability Date: 10/09/2013

Providers

Benefit Engine

PeopleSoft

Rehab Vendors

Age at DCI: 50

Alerts

Contacts

Summary & Action Plan

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▲ Most Recent Claim Information

Own/Any Occ. Definition	Transition Status	SS Status	Transition Date
Own Occ w/Any Employer	Pending	Pending	04/07/2016

[Appeal Determination](#)  
(04/13/2015)

[Determination](#)  
(01/12/2015)

IHD Referral  
(Not Available)

[Initial Assessment](#)  
(02/18/2014)

[Intake Script](#)  
(02/05/2014)

[LTD Claimant Interview](#)  
(11/06/2014)

Review  
(Not Available)

[Triage](#)  
(02/27/2014)

▲ Most Recent Summary & Action Plan

Most Recent Summary

Last Update Date	Creator	Title
4/13/2015 7:10:24 PM	CHARLAI LANG	Disability Appeals Specialist

Topic: Appeal Determination , Appeal Decision : Upheld  
[NO DATA AVAILABLE FOR IMPORT]

Most Recent Action Plan

Last Update Date	Creator	Title
1/12/2015 11:36:36 AM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST

Topic: LTD Disability Determination , Disability Determination : Terminate  
TERM BENEFITS AS OF 1/08/2015 DUE TO INSUFFICIENT MEDICAL INFORMATION TO SUPPORT CLAIM  
FORWARD TO STS FOR SIGN OFF ON TERM. INFORMEE OF CLAIM STATUS

Manage Notes: 

ADD NEW

Summary & Action Plan Notes History

Expand All Details

Note Type FilterNoneShowAllNotes

Note Type	Last Update Date	Creator	Title	Task
▼ Summary	1/12/2015 11:36:36 AM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	LTD Disability Determination
Topic: LTD Disability Determination , Disability Determination : Terminate				
▼ Action Plan	11/6/2014 1:20:29 PM	SHAWNDR LEE	LTD BENEFIT MANAGER	LTD Claimant Interview
Topic: LTD Claimant Interview				
▼ Summary	5/7/2014 1:17:14 PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	LTD Disability Determination

Topic: LTD Disability Determination , Disability Determination : Approved

▼ Action Plan	5/7/2014 1:17:14 PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	LTD Disability Determination
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Topic: LTD Disability Determination , Disability Determination : Approved

▼ Summary	2/27/2014 9:43:19 AM	CAROLE BISHOP	UM Nurse Consultant	LTD Triage Review
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Topic: LTD Triage Review

▼ Action Plan	2/27/2014 9:43:19 AM	CAROLE BISHOP	UM Nurse Consultant	LTD Triage Review
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Topic: LTD Triage Review

▼ Summary	2/18/2014 2:25:49 PM	MARIBEL AMOR	Senior LTD Claim Analyst	LTD Initial Assessment
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Topic: LTD Initial Assessment

▼ Action Plan	2/18/2014 2:25:49 PM	MARIBEL AMOR	Senior LTD Claim Analyst	LTD Initial Assessment
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Topic: LTD Initial Assessment

# Central Note System - View All Report

[Click Here To Access The Excel Export View](#)

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

## Summary & Action Plan Notes History

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	TASK
Summary	04/13/2015 7:10:24PM	CHARLAI LANG	Disability Appeals Specialist	Appeal Determination

Topic: Appeal Determination , Appeal Decision : Upheld  
[NO DATA AVAILABLE FOR IMPORT]

Summary	01/12/2015 11:36:36AM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	LTD Disability Determination
---------	-----------------------	------------------------	-----------------------------	------------------------------

Topic: LTD Disability Determination , Disability Determination : Terminate  
FDA:10/9/2013 LTD: 4/7/2014 EE CO-MORBIDS: Diabetes, HTN, GERD EE IS A 51Y/O male INSIDE SALES ACCT MGMT III, WHO WENT ON LEAVE AS OF 10/09/2013 DUE TO DX OF ROTATOR CUFF REPAIR. Rotator Cuff Repairs on 10/11/2013 & 1/31/14. Job Requirements: EE IS REQUIRED TO SIT THE MAJORITY OF HIS WORK DAY, NO LIFTING IS REQUIRED. EE IS REQUIRED TO HAVE THE ABILITY TO FOLLOW DIRECTIONS AND ROUTINES, PLAN AND ORGANIZE, AND ANALYZE DATA. MEDICAL INFORMATION FROM DR. PAUL BUECHEL ON 12/23/2014 INFORMED THAT EE C/O LOW BACK PAIN. HOWEVER THERE WERE NO EXAM FINDINGS THAT WOULD SUPPORT IMPAIRMENT FROM EE OWN SEDENTARY OCCUPATION. AT THIS TIME LTD CLAIM WILL BE TERMED DUE TO INSUFFICIENT MEDICAL INFORMATION.

Action Plan	01/12/2015 11:36:36AM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	LTD Disability Determination
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Topic: LTD Disability Determination , Disability Determination : Terminate  
TERM BENEFITS AS OF 1/08/2015 DUE TO INSUFFICIENT MEDICAL INFORMATION TO SUPPORT CLAIM FORWARD TO STS FOR SIGN OFF ON TERM. INFORMEE OF CLAIM STATUS

Action Plan	11/06/2014 1:20:29PM	SHAWNDR A LEE	LTD BENEFIT MANAGER	LTD Claimant Interview
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Topic: LTD Claimant Interview  
DBM will request medicals from treating providers DBM will update LTD action plan

Summary	05/07/2014 1:17:14PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	LTD Disability Determination
---------	----------------------	------------------------	-----------------------------	------------------------------

Topic: LTD Disability Determination , Disability Determination : Approved  
FDA:10/9/2013 LTD: 4/7/2014 EE CO-MORBIDS: Diabetes, HTN, GERD EE IS A 50YOF INSIDE SALES ACCT MGMT WHO WENT ON LEAVE DUE TO DX OF ROTATOR CUFF REPAIR. JOB REQUIREMENTS: SEDPDL;Lift/carry/push/pull: up to 10 lbs occasionally FUNCTIONALITY:Rotator Cuff Repairs on 10/11/2013 & 1/31/14 \*\* OV 2/11/2014: EE had sutures removed, continue sling work on pendulum exercises & passive ROM in therapy - NOV 3/11/2014 \*\* 3/6/14 notes height 6 foot and weight 243 lbs.EE was seen this date for a complete physical.Review of exam reveals a well developed male in no acute distress, EE is obese and all the exam findings are normal, including gait & station, muscle strength/tone are normal. EE to f/u with this provider in 1 year & are far as back pain it 'is persistent & definately disrupting patients life, will refer to SJP for further eval & treatment. Continue PT as it is helping. \*\* Peer review dated 4/20/14 notes restrictions would be appropriate of sitting, 30 minutes at a time up to 5 1/2 hours per day w/ opportunity to stand, stretch, and/or shift positions every 15 minutes for 2 minutes at one time. Stand/walk: 30 minutes at a time up to 5 1/2 hours per day combined. Lift/carry/push/pull: up to 10 lbs occasionally.Reach overhead or above desk level: Never Reach at desk level: Frequently Use of hands to type, hold, grasp, fasten, grip while seated: Unrestricted. Peer notes these restrictions are appropriate from 3/21/14-5/31/14. \*\* 5/7/2014 -DBM confirmed with Dr. Renfro's office, ee had atrophy left knee sx 4/18/14, and a f/u visit 4/26/2014.

Action Plan	05/07/2014 1:17:14PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST	LTD Disability Determination
-------------	----------------------	------------------------	-----------------------------	------------------------------

Topic: LTD Disability Determination , Disability Determination : Approved  
STS approving LTD benefits, due to 4/18/2014 sx ee does not have the functional capacity to perform the core elements of his owc occupation as a Inside Sales Acct Mgmt which requires Lift/carry/push/pull: up to 10 lbs occasionally \*\*\*\*\* require actual sx notes continue to conduct on-going tpc

Summary	02/27/2014 9:43:19AM	CAROLE BISHOP	UM Nurse Consultant	LTD Triage Review
---------	----------------------	---------------	---------------------	-------------------

Topic: LTD Triage Review  
2/27/14 LTD SNR Triage Review, CJB, RN - STD EOB 4/6/14 - LTD start 4/7/14 - Terminated - Claimant is a 50 y.o.m. Job title is INSIDE SALES ACCOUNT MGMT III, reported as Sedentary. JD in STD claim reports the claimant sits 8 hrs of his 8 hr shift/day, no lifting, reaching, pulling, pushing or over head work. Job entails telephone, computer, desk work. - DOH: 5/22/06 - Dx's: Massive Bilateral RTC Tears. Claimant underwent 10/11/13: 1. Extensive debridement of left rotator cuff, bursa and labrum. 2. Biceps tenodesis. 3. Open RTC repair including decompression. On 1/31/14 the claimant underwent: 1. Extensive debridement of right labrum and RTC. 2. Subacromial bursa debridement and subacromial decompression. 3. Excision of distal clavicle, separate compartment. 4. Open RTC repair. - Most recent exam findings submitted, is Orthopedic Surgeon, Dr. Renfro's exam dated 2/11/14 and reports, "F/U of his righr shoulder surgery. Wounds look good. We discussed massive tear with him. He is to work on pendulum exercises and PROM exercises and we will see him back in 1 month. - MD also reported PMH of: Asthma; DDD Lumbar; HTN; Sciatica; Sprain/Strain, Lumbar; Medial meniscus tear 1/28/14; and S/P Left Knee surgery in 2004. - Rec'd PT eval dated 1/20/14 for Dx's of Lumbago and Difficulty in walking. Eval reported the claimant has LBP impacting his ADL's, working, sitting and standing. Was unable to assess joint mobility on 1/20/14 secondary to muscle guarding. ROM of spine on 1/20/14 was at 50% on extension; and 75% on flexion with increased pain and left and right side bending. Palpation of lumbosacral region musculature on left and right revealed severe spasms and pain. Claimant was only able to sit for 1 minute before position change required secondary to pain. - Lastest PT progress note reports the claimant can now sit for 8 minutes before position change required due to pain; Mild spasms and pain along lumbosacral musculature; ROM of lumbar spine is 100%.

# Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

## Summary & Action Plan Notes History

Subject Filter : ALL

SUBJECT	LAST UPDATE DATE	CREATOR	TITLE	TASK
Action Plan	02/27/2014 9:43:19AM	CAROLE BISHOP	UM Nurse Consultant	LTD Triage Review

Topic: LTD Triage Review

LTD DBM Directives: 1. Claim requires Dr. Renfro's March 2014 exam findings. Per LOV on 2/11/14, will be in 4 weeks. 2. DBM has already requested Dr. Cote's exam findings, test results and treatment plan, regarding the claimant's back pain. 3. Claimant reports back pain from an MVA. MVA was not reported during the PT 1/20/14 eval. Is there subrogation? 4. In the future, claimant may require a VRC referral as this EE's job tasks are reported as a PDL of sedentary, and does require prolonged sitting. VRC could evaluate for the appropriateness of an adjustable height workstation, to allow the claimant to change from sitting to standing position as needed, to facilitate RTW. 5. Please request PT's most recent progress note in mid 3/14, for both the shoulders and back. 6. Please alert this SNR once Dr. Renfro's and Dr. Cote's exam findings are rece'd. 7. Please image the JD from STD into LTD claim.

Summary	02/18/2014 2:25:49PM	MARIBEL AMOR	Senior LTD Claim Analyst	LTD Initial Assessment
---------	----------------------	--------------	--------------------------	------------------------

Topic: LTD Initial Assessment

Claim received: 02/05/2014 LTD determination date: 04/07/2014 IHD: No ROI: NO EOB: 07/31/2018 Fiduciary/ERISA: ERISA PLAN Control/Plan: 620245 0476626 033 00001 DD 004 Eligibility: Policy effective: 1/1/09 Minimum # of hrs: 25 Probationary period: First day after 30 days of employment. Contributory: Contributory Pre or post tax: post-tax Elimination period: 180 days Date of hire: 05/22/2006. Info will be verified once paycheck rcvd Mandatory Rehab: Yes MRBE (source) = Claimant's monthly pre-disability earnings: To be verified Benefit Amount = Actual benefit amount: to be verified. Offsets/FSS/PSS = None at this time FIT/SIT = benefit is taxable Deductions: None at this time ISO = No needed at this time SSD = New case, DBM will advise clmt of ALLSUP services. Claimant's end of STD benefit: 04/05/2014 Benefit percentage/amount: 60% of monthly pre-disability earnings. Max/min benefit: minimum monthly benefit of \$100.00 or 10% of gross monthly benefit level which ever is greater; maximum monthly benefit is \$10,000 Test change/transition: 24 months Forms received to date: none

Action Plan	02/18/2014 2:25:49PM	MARIBEL AMOR	Senior LTD Claim Analyst	LTD Initial Assessment
-------------	----------------------	--------------	--------------------------	------------------------

Topic: LTD Initial Assessment

I am currently waiting for eligibility confirmation from Dell.

Client Name: Dell Inc

Claim Status: Closed

Date of Birth: REDACTED

Contract Situs: TX

Preferred Contact#: REDACTED

Current Analytics:

Work Capacity Level: No Current Work Capacity

Claim Owner: LEE, SHAWNDR

Age: 52

Tier: Tier 3

Phone (Mobile)

End Of Benefit(EOB): 10/31/2028

6 Month Duration 3

12 Month Duration 4

18 Month Duration 5

24+ Month Duration 7

(Less Info)

IHD Consent Effective: N/A

OP Balance: N/A

Gender: Male

Estimated RTW:

Disability Date: 10/09/2013

Providers

Benefit Engine

PeopleSoft

Rehab Vendors

Age at DCI: 50

Alerts

Contacts

Summary & Action Plan

Medical

Vocational

Financial

▲ Most Recent Claim Information

Mandatory Rehab	Job Title	Occupation	Occupation Physical Demand Level
Mandatory	INSIDE SALES ACCOUNT MGMT III		

Initial Vocational Rehab Review  
(Not Available)

Rehabilitation Program  
(Not Available)

[Job Description](#)  
(01/09/2015)

[Work History/Education](#)  
(02/20/2014)

Occupation Analysis  
(Not Available)

Rehab Occ Skills Assessment  
(Not Available)

Rehab TSA/LM Review  
(Not Available)

Rehab Transition Review  
(Not Available)

Rehab Voc Assessment  
(Not Available)

Manage Notes: 

ADD NEW

Vocational Notes History

Expand All Details

Show All Notes

Last Update Date	Creator	Title
▼ 11/6/2014 1:20:29 PM	SHAWNDR LEE	LTD BENEFIT MANAGER
Topic: Early Any Occupation Assessment		
▼ 8/15/2014 1:01:06 PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST
Topic: Early Any Occupation Assessment		
▼ 2/18/2014 2:25:49 PM	MARIBEL AMOR	Senior LTD Claim Analyst
Topic: Early Any Occupation Assessment		
▼ 2/14/2014 2:18:46 PM	MARIBEL AMOR	Senior LTD Claim Analyst
Topic: Early Any Occupation Assessment		

## Central Note System - View All Report

Company : Dell Inc

Employee Name : DAVIS, ARTHUR

Employee ID : 157406572

[Click Here To Access The Excel Export View](#)

### Vocational Notes History

LAST UPDATE DATE	CREATOR	TITLE
11/06/2014 1:20:29PM	SHAWNDRAL EEE	LTD BENEFIT MANAGER
Topic: Early Any Occupation Assessment *		
08/15/2014 1:01:06PM	WANDA GREENE-CELESTINE	SENIOR TECHNICAL SPECIALIST
Topic: Early Any Occupation Assessment n/a		
02/18/2014 2:25:49PM	MARIBEL AMOR	Senior LTD Claim Analyst
Topic: Early Any Occupation Assessment Will depend on the results of treatment (PT, SP surgery, and medication)		
02/14/2014 2:18:46PM	MARIBEL AMOR	Senior LTD Claim Analyst
Topic: Early Any Occupation Assessment I need the progress notes to assess.		

Benefit Payments

Client Name: Dell

Last Name: DAVIS

First Name: ARTHUR

Middle initial: C

Employee SSN: XXX-XX-REDACTE

Employee ID: XXX-XX-REDACTE

Claim ID: 9452367

Product: LTD

Work Status: Not At Work

Benefit Information:

Payment Method:CHECK		Benefit Schedule:MONTHLY		Payroll Days:30ACTUAL		Payroll Start Date:SUNDAY		Payroll End Date:SATURDAY		Allsource:0.0000 %		Backdoor:0.0000 %	
<u>Benefit Salary</u>	<u>Payroll Days</u>	<u>Benefit %</u>	<u>From</u>	<u>Through</u>	<u>From</u>	<u>Through</u>	<u>Duration To Age</u>	<u>Minimum Benefit</u>				<u>Maximum Benefit</u>	
\$5,284.3442	30ACTUAL	60.0000 %	0 earnings	999999 earnings			65	Greater Of \$100.0000 or 10% of Gross After Max				\$10,000.0000	

Benefit Payments History:   Paging: ☒

Payment Status Filter:

- ☐ Payments (Lumped/Paid/Reversed)
- ☐ Other (Cancelled/Rejected/RevCncl/RevRqst)
- ☐ Pending Payments (Approved/Ded>Net/In Error/In Process/Negative/Pending/Suspended)
- ☐ Show only Benefit Engine Payments (Underpayment, Disability Survivor Benefit, Accelerated Disability Survivor Benefit)

Filter Payments | Clear Filter |

Details	Approve All	Status	Locked	Status Date	Ben Eng Pmt	Check Date	Check #	EFT	Payment From	Payment Through	Period Gross Benefit	Net Benefit After Offsets	Net Benefit After Offsets & Ovrpmnts	Net Pay	Immediate Payment Flag	Internal Note	Cashed
<a href="#">Details</a>	<input type="checkbox"/>	Cancelled		01/12/2015 12:03 PM					04/01/2016	04/06/2016			\$634.1200				
<a href="#">Details</a>	<input type="checkbox"/>	Cancelled		01/12/2015 12:03 PM					03/01/2016	03/31/2016			\$3,170.6100				
<a href="#">Details</a>	<input type="checkbox"/>	Cancelled		01/12/2015 12:03 PM					02/01/2016	02/29/2016			\$3,170.6100				
<a href="#">Details</a>	<input type="checkbox"/>	Cancelled		01/12/2015 12:03 PM					01/01/2016	01/31/2016			\$3,170.6100				
<a href="#">Details</a>	<input type="checkbox"/>	Cancelled		01/12/2015 12:03 PM					12/01/2015	12/31/2015			\$3,170.6100				
<a href="#">Details</a>	<input type="checkbox"/>	Cancelled		01/12/2015 12:03 PM					11/01/2015	11/30/2015			\$3,170.6100				
<a href="#">Details</a>	<input type="checkbox"/>	Cancelled		01/12/2015 12:03 PM					10/01/2015	10/31/2015			\$3,170.6100				
<a href="#">Details</a>	<input type="checkbox"/>	Cancelled		01/12/2015 12:03 PM					09/01/2015	09/30/2015			\$3,170.6100				
<a href="#">Details</a>	<input type="checkbox"/>	Cancelled		01/12/2015 12:03 PM					08/01/2015	08/31/2015			\$3,170.6100				
<a href="#">Details</a>	<input type="checkbox"/>	Cancelled		01/12/2015 12:03 PM					07/01/2015	07/31/2015			\$3,170.6100				
<a href="#">Details</a>	<input type="checkbox"/>	Cancelled		01/12/2015 12:03 PM					06/01/2015	06/30/2015			\$3,170.6100				
<a href="#">Details</a>	<input type="checkbox"/>	Cancelled		01/12/2015 12:03 PM					05/01/2015	05/31/2015			\$3,170.6100				
<a href="#">Details</a>	<input type="checkbox"/>	Cancelled		01/12/2015 12:03 PM					04/01/2015	04/30/2015			\$3,170.6100				
<a href="#">Details</a>	<input type="checkbox"/>	Cancelled		01/12/2015 12:03 PM					03/01/2015	03/31/2015			\$3,170.6100				
<a href="#">Details</a>	<input type="checkbox"/>	Cancelled		01/12/2015 12:03 PM					02/01/2015	02/28/2015			\$3,170.6100				

1 [2](#)



### Offsets:

Effective Date	End Date	Offset Description	Offset Type	Amount (\$)	Frequency	Lump Sum (\$)
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**Deductions:**

Effective Date	End Date	Deduction Description	Deduction Type	Tax Type	Amount (\$)	Frequency	Disallow	Payee
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Submit

Cancel

Create Payment

Underpayment

Benefit Payments

Client Name: Dell

Employee ID: XXX-XX-REDACTED

Last Name: DAVIS

Claim ID: 9452367

First Name: ARTHUR

Product: LTD

Middle initial: C

Work Status: Not At Work

Employee SSN: XXX-XX-REDACTED

Benefit Information:

Payment Method:CHECK		Benefit Schedule:MONTHLY		Payroll Days:30ACTUAL		Payroll Start Date:SUNDAY		Payroll End Date:SATURDAY		Allsource:0.0000 %		Backdoor:0.0000 %	
<u>Benefit Salary</u>	<u>Payroll Days</u>	<u>Benefit %</u>	<u>From</u>	<u>Through</u>	<u>From</u>	<u>Through</u>	<u>Duration To Age</u>	<u>Minimum Benefit</u>				<u>Maximum Benefit</u>	
\$5,284.3442	30ACTUAL	60.0000 %	0 earnings	999999 earnings			65	Greater Of \$100.0000 or 10% of Gross After Max				\$10,000.0000	

Benefit Payments History:   Paging: ☒

Payment Status Filter:

☐ Payments (Lumped/Paid/Reversed)

☐ Other (Cancelled/Rejected/RevCncl/RevRqst)

☐ Pending Payments (Approved/Ded>Net/In Error/In Process/Negative/Pending/Suspended)

☐ Show only Benefit Engine Payments (Underpayment, Disability Survivor Benefit, Accelerated Disability Survivor Benefit)

Filter Payments

Clear Filter

Details	Approve All <input type="checkbox"/>	Status	Locked	Status Date	Ben Eng Pmt	Check Date	Check #	EFT	Payment From	Payment Through	Period Gross Benefit	Net Benefit After Offsets	Net Benefit After Offsets & Ovrpmnts	Net Pay	Immediate Payment Flag	Internal Note	Cashed
<a href="#">Details</a>	<input checked="" type="checkbox"/>	Paid		01/13/2015 02:58 PM		1/15/2015	8247561	<input checked="" type="checkbox"/>	01/01/2015	01/11/2015	\$1,162.5600	\$1,162.5600	\$1,162.5600	\$1,162.56	<input checked="" type="checkbox"/>	[01/12/2015 02:48 PM] WANDA GREENECELESTINE The Benefit Level Authority Review has been completed and payment approved. <a href="#">(Hover for More)</a>	Y
<a href="#">Details</a>	<input checked="" type="checkbox"/>	Paid		12/17/2014 04:40 PM		12/19/2014	8222821	<input checked="" type="checkbox"/>	12/01/2014	12/31/2014	\$3,170.6100	\$3,170.6100	\$3,170.6100	\$3,170.61			Y
<a href="#">Details</a>	<input checked="" type="checkbox"/>	Paid		11/19/2014 07:15 PM		11/21/2014	8189768	<input checked="" type="checkbox"/>	11/01/2014	11/30/2014	\$3,170.6100	\$3,170.6100	\$3,170.6100	\$3,170.61			Y
<a href="#">Details</a>	<input checked="" type="checkbox"/>	Paid		10/17/2014 03:35 PM		10/21/2014	8153794	<input checked="" type="checkbox"/>	10/01/2014	10/31/2014	\$3,170.6100	\$3,170.6100	\$3,170.6100	\$3,170.61			Y
<a href="#">Details</a>	<input checked="" type="checkbox"/>	Paid		09/17/2014 03:35 PM		9/19/2014	8119332	<input checked="" type="checkbox"/>	09/01/2014	09/30/2014	\$3,170.6100	\$3,170.6100	\$3,170.6100	\$3,170.61			Y
<a href="#">Details</a>	<input checked="" type="checkbox"/>	Paid		08/19/2014 02:32 PM		8/21/2014	8085553	<input checked="" type="checkbox"/>	08/01/2014	08/31/2014	\$3,170.6100	\$3,170.6100	\$3,170.6100	\$3,170.61			Y
<a href="#">Details</a>	<input checked="" type="checkbox"/>	Paid		07/16/2014 05:51 PM		7/21/2014	8050808	<input checked="" type="checkbox"/>	07/01/2014	07/31/2014	\$3,170.6100	\$3,170.6100	\$3,170.6100	\$3,170.61			Y
<a href="#">Details</a>	<input checked="" type="checkbox"/>	Paid		06/18/2014 06:37 PM		6/20/2014	8019260	<input checked="" type="checkbox"/>	06/01/2014	06/30/2014	\$3,170.6100	\$3,170.6100	\$3,170.6100	\$3,170.61			Y
<a href="#">Details</a>	<input checked="" type="checkbox"/>	Paid		05/19/2014 03:10 PM		5/21/2014	7986422	<input checked="" type="checkbox"/>	05/01/2014	05/31/2014	\$3,170.6100	\$3,170.6100	\$3,170.6100	\$3,170.61			N
<a href="#">Details</a>	<input checked="" type="checkbox"/>	Paid		05/08/2014 03:21 PM		5/12/2014	7973646	<input checked="" type="checkbox"/>	04/07/2014	04/30/2014	\$2,536.4900	\$2,536.4900	\$2,536.4900	\$2,536.49	<input checked="" type="checkbox"/>		N

[1](#) [2](#)

### Offsets:

Effective Date	End Date	Offset Description	Offset Type	Amount (\$)	Frequency	Lump Sum (\$)
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**Deductions:**

Effective Date	End Date	Deduction Description	Deduction Type	Tax Type	Amount (\$)	Frequency	Disallow	Payee
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Submit

Cancel

Create Payment

Underpayment

**CODY ALLISON &  
ASSOCIATES**



K. Cody Allison, Esq.

501 Union Street, Suite 502  
Nashville, Tennessee 37219  
T: (615) 234-6000  
F: (615) 727-0175  
cody@codyallison.com

May 27, 2015

**CERTIFIED MAIL # 7014 2870 0001 1250 0884**  
**RETURN RECEIPT REQUESTED and**  
**Via Fax: (855) 733-1262**

Ms. Charlai Lang  
c/o Aetna Life Insurance Co.  
P.O. Box 14578  
Lexington, KY 40512-4578

Re: Our Client: Arthur Davis  
Claim No.: 9452367

Dear Ms. Lang:

My office has been retained to represent Mr. Arthur Davis regarding the denial of his long-term disability benefits.

I sent you two letters on April 28, 2015 and to date, I have not received a response back regarding the documents I have requested as well as opening up Mr. Davis' appeal so our office may file an appropriate appeal on his behalf.

My paralegal, Barb Krautheim, left you a voice mail message today regarding our representation of Mr. Davis as well as requesting a response from you regarding our April 28, 2015 letters to your attention.

Upon receipt of this letter, please advise as to when my office can expect to receive the requested documents as well as a decision to open his appeal.

I look forward to hearing from you.

With kind regards,

CODY ALLISON & ASSOCIATES

*Cody Allison w/permission*  
*Barb Krautheim*

By: K. Cody Allison

KCA/bk  
cc: Mr. Arthur Davis

0001150002

**CERTIFIED MAIL**



UNITED STATES  
POSTAL SERVICE



1000

40512

**\$6.49**  
00091687-

40512

**THE UNIVERSITY OF CHICAGO**

Case 1:15-cv-00086 Document 13-1 Filed 02/18/16 Page 329 of 1151 PageID# 373

# UPS CampusShip: View/Print Label

1. Ensure there are no other shipping or tracking labels attached to your package. Select the Print button on the print dialog box that appears. Note: If your browser does not support this function select Print from the File menu to print the label.
2. Fold the printed label at the solid line below. Place the label in a UPS Shipping Pouch. If you do not have a pouch, affix the folded label using clear plastic shipping tape over the entire label.
3. **GETTING YOUR SHIPMENT TO UPS**  
 UPS locations include the UPS Store®, UPS drop boxes, UPS customer centers, authorized retail outlets and UPS drivers.  
 Schedule a same day or future day Pickup to have a UPS driver pickup all your CampusShip packages.  
 Hand the package to any UPS driver in your area.  
 Take your package to any location of The UPS Store®, UPS Drop Box, UPS Customer Center, UPS Alliances (Office Depot® or Staples®) or Authorized Shipping Outlet near you. Items sent via UPS Return Services(SM) (including via Ground) are also accepted at Drop Boxes. To find the location nearest you, please visit the Resources area of CampusShip and select UPS Locations.




## Customers with a Daily Pickup

Your driver will pickup your shipment(s) as usual.

Claim # 9452367

Corn  
Outgoing

FOLD HERE

STEPHEN DECKER 207-791-7625 AETNA 175 RUNNING HILL ROAD, SUITE 3 SOUTH PORTLAND ME 04106  <b>SHIP TO:</b> R CODY ALLISON CODY ALLISON & ASSOCIATES 501 UNION ST. STE 502 NASHVILLE TN 37219	0.8 LBS LTR 1 OF 1	<b>TN 371 9-02</b> 	<b>2</b> <b>UPS 2ND DAY AIR</b> TRACKING #: 1Z 1E7 5E3 02 9032 7387 	BILLING: P/P Reference # 1: 11640 
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# - Fax Transmission

**To:** Ms. Charlai Lang c/o Aetna

**From:** Nikki Redding

**Fax:** 18557331262

**Date:** 5/27/2015

**RE:** Arthur Davis

**Pages:** 2

---

**Comments:**

Nikki Redding, Paralegal  
Cody Allison & Associates, PLLC  
501 Union St., Suite 502  
Nashville, TN 37219  
Voice: (615) 234-6000  
Fax: (615) 727-0175  
nikki@codyallison.com

THE INFORMATION CONTAINED IN THIS E-MAIL MESSAGE IS PRIVILEGED AND CONFIDENTIAL INFORMATION INTENDED FOR THE USE OF THE ADDRESSEE LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR THE EMPLOYEE OR AGENT RESPONSIBLE FOR DELIVERING THIS MESSAGE TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING, DISTRIBUTION, OR THE TAKING OF ANY ACTION IN RELIANCE ON THE ENCLOSED INFORMATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS E-MAIL IN ERROR, PLEASE CONTACT NIKKI REDDING IMMEDIATELY.



K. Cody Allison, Esq.

501 Union Street, Suite 502  
Nashville, Tennessee 37219  
T: (615) 234-6000  
F: (615) 727-0175  
cody@codyallison.com

May 27, 2015

**CERTIFIED MAIL # 7014 2870 0001 1250 0884**  
**RETURN RECEIPT REQUESTED and**  
**Via Fax: (855) 733-1262**

Ms. Charlai Lang  
c/o Aetna Life Insurance Co.  
P.O. Box 14578  
Lexington, KY 40512-4578

Re: Our Client: Arthur Davis  
Claim No.: 9452367

Dear Ms. Lang:

My office has been retained to represent Mr. Arthur Davis regarding the denial of his long-term disability benefits.

I sent you two letters on April 28, 2015 and to date, I have not received a response back regarding the documents I have requested as well as opening up Mr. Davis' appeal so our office may file an appropriate appeal on his behalf.

My paralegal, Barb Krautheim, left you a voice mail message today regarding our representation of Mr. Davis as well as requesting a response from you regarding our April 28, 2015 letters to your attention.

Upon receipt of this letter, please advise as to when my office can expect to receive the requested documents as well as a decision to open his appeal.

I look forward to hearing from you.

With kind regards,

CODY ALLISON & ASSOCIATES

*Cody Allison w/permission*  
*Barb Krautheim*

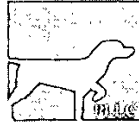
By: K. Cody Allison

KCA/bk

cc: Mr. Arthur Davis



**CODY ALLISON &  
ASSOCIATES**



K. Cody Allison, Esq.

501 Union Street, Suite 502  
Nashville, Tennessee 37219  
T: (615) 234-6000  
F: (615) 727-0175  
cody@codyallison.com

April 28, 2015

**CERTIFIED MAIL # 7014 1200 0000 6135 1971  
RETURN RECEIPT REQUESTED**

**VIA FACSIMILE: (855) 733-1262**

Ms. Charlai Lang  
c/o Aetna Life Insurance Co.  
P.O. Box 14578  
Lexington, KY 40512-4578

**Re: My Client: Arthur Davis  
Claim No.: 9452367**

Dear Ms. Lang:

This firm represents Arthur Davis regarding his denial of his long-term disability benefits through Aetna Life Insurance Company.

I am hereby requesting the following documents on behalf of my client in order to assist in my continuing evaluation of this claim:

1. All plan documents including insurance contracts.
2. A copy of the applicable long term disability insurance policy.
3. Copies of all documents reflecting any and all agreements between the employer and any and all insurance companies, claims administrators and fiduciaries regarding disability insurance policies or plans.
4. Copies of all correspondence to, from and regarding my client, including all claim forms, cover letters, physicians' statements, and other documents.
5. Copies of all medical records, vocational records, rehabilitation records and other documents regarding my client's physical and mental condition, including, but not limited to, all physicians' statements, all reports, testing data and handwritten notes.
6. If this claim has been, or will be reviewed by any medical professional at the carrier or administrator's request, all correspondence to and from the medical professional and all documents reviewed by the medical professional.
7. If this claim has been, or will be reviewed by any vocational professional at the carrier or

0430150003

administrator's request, all correspondence to and from the vocational professional and all documents reviewed by the vocational professional.

8. My client's job description at the time my client stopped working.
9. Surveillance reports, video and audio tapes, correspondence to and from investigators, and investigative billing information, as well as the un-edited surveillance CDs.

**If there is any charge for copying the documents we have requested, please notify me immediately in writing. If there are any other reasons why you cannot produce the documents we have requested, or if there are any special procedures which must be followed to secure copies of the documents we have requested herein, please advise my office in writing immediately.** A signed authorization form is enclosed for your records.

If you have any questions please let me know.

With kind regards,

CODY ALLISON & ASSOCIATES, PLLC

By: K. Cody Allison Esq.

KCA/vnr  
Enclosure  
cc: Mr. Arthur Davis

0430150003

Authorization

I, Arthur Davis, hereby authorize and direct Aetna to send all of my disability checks and/or settlement checks to my attorney, Cody Allison, and to make the checks payable to Cody Allison & Associates, PLLC and Arthur Davis to be put into Cody Allison & Associates, PLLC Trust Account to be distributed to Arthur Davis. I expressly revoke authorization to use prior provided accounts for payments of benefits.

Please mail the checks to the below address:

**CODY ALLISON & ASSOCIATES, PLLC**

The Union Building  
501 Union Street, Suite 502  
Nashville, Tennessee 37219

4/24/15  
Date

Arthur Davis  
Arthur Davis

0420150003

**AUTHORIZATION FOR RELEASE OF INFORMATION RELATING TO  
ERISA PLANS AND APPOINTMENT OF REPRESENTATIVE**

TO: **Aetna**

**YOU ARE NOTIFIED THAT** I hereby appoint **CODY ALLISON & ASSOCIATES**, as my attorney to represent me in connection with any and all claims on my behalf relating to my benefit claim, i.e., claim for short-term and/or long-term disability benefits.

**YOU ARE AUTHORIZED AND REQUESTED** to release to my attorney, **CODY ALLISON & ASSOCIATES**, 501 Union Street, Suite # 502, The Union Building, Nashville, TN 37219, any coping service acting pursuant to this authorization, any and all documents and other items relevant this claim including, but not limited to, plan modifications, any and all documents contained in my personnel file and/or my benefit claim file including, but not limited to, any and all medical records, including admission notes, medical history sheets, test results, x-rays, and any and all other records in your possession relating to my claim, inclusive of salary information and other documents relating to offset of benefits/coordination of benefits with social security (if this is a disability claim), as well as notes and comments made by claim reviewers.

The undersigned releases you or anyone working on your behalf from any privilege, right, or liability which you may have in said records.

This authorization shall remain in effect from the date below until revoked; and the request made herein shall be deemed continuing.

Date: 4/24/15

*Aetna A. D. G.*  
CLIENT

**REDACTED**

**SOCIAL SECURITY NUMBER**

**REDACTED**

**DATE OF BIRTH**

29 U.S.C. § 11321(C) provides:

Any administrator who fails or refuses to comply with a request for any information which such administrator is required by this sub chapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary in the amount of up to \$110 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

0430150003

**AUTHORIZATION TO COMMUNICATE WITH  
CODY ALLISON & ASSOCIATES, PLLC**

I, **Arthur Davis**, hereby authorize any administrator, fiduciary, governmental entity, insurance company, or other individual or company to communicate with my attorney and representatives of my attorney.

**CODY ALLISON & ASSOCIATES, PLLC**

501 Union Street, Suite # 502

The Union Building

Nashville, TN 37219

Phone: (615) 234-6000

Fax: (615) 727-0175

  
\_\_\_\_\_  
CLIENT'S SIGNATURE

4/24/15  
DATE

Arthur Davis  
CLIENT'S PRINTED/TYPED NAME

**REDACTED**  
\_\_\_\_\_  
SOCIAL SECURITY NUMBER

0420150003

Cody Allison & Associates, PLLC  
501 Union Street, Suite 502  
Nashville, TN 37219

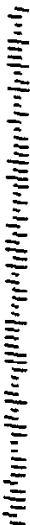
**CERTIFIED MAIL™**



7014 1200 0000 6135 1971

Ms. Charlai Lang  
c/o Aetna Life Insurance Co.  
P.O. Box 14578  
Lexington, KY 40512-4578

4051234578 B050



1000



40512

U.S. POSTAGE  
PAID  
NASHVILLE, TN  
37219  
APR 28 9 15  
AMOUNT  
**\$7.19**  
00091687-14

**UPS CampusShip: View/Print Label**

1. **Ensure there are no other shipping or tracking labels attached to your package.** Select the Print button on the print dialog box that appears. Note: If your browser does not support this function select Print from the File menu to print the label.
2. **Fold the printed label at the solid line below.** Place the label in a UPS Shipping Pouch. If you do not have a pouch, affix the folded label using clear plastic shipping tape over the entire label.
3. **GETTING YOUR SHIPMENT TO UPS**  
**UPS locations include the UPS Store®, UPS drop boxes, UPS customer centers, authorized retail outlets and UPS drivers.**  
 Schedule a same day or future day Pickup to have a UPS driver pickup all your CampusShip packages.  
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 Take your package to any location of The UPS Store®, UPS Drop Box, UPS Customer Center, UPS Alliances (Office Depot® or Staples®) or Authorized Shipping Outlet near you. Items sent via UPS Return Services(SM) (including via Ground) are also accepted at Drop Boxes. To find the location nearest you, please visit the Resources area of CampusShip and select UPS Locations.

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Your driver will pickup your shipment(s) as usual.

*Outgoing*

FOLD HERE

*9452367*

*28 April 2015*

1 LBS 1 OF 1 COLLEEN SPEARS AETNA 175 RUNNING HILL ROAD SOUTH PORTLAND ME 04105  SHIP TO: ARTHUR C. DAVIS JR 1147 WRIGHTS MILL ROAD SPRING HILL TN 37174-2798	TN 384 1-01 	UPS 2ND DAY AIR TRACKING #: 1Z 1E7 5E3 02 9864 5260 2		BILLING: P/P Reference # 1: 11640  CS 1121-01 WINTERB 03/04/04/2015
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## CLAIM REVIEW CHECK

CLAIM # 8893435 / 9452367

NAME: ARTHUR DAVIS

CERTIFICATE YES SOB YES COVER LETTER YES

GR-9 (29)

FIRST REVIEW/DATE

COLLEEN 28 April 2015

SECOND REVIEW/DATE

ROBYN 28 April 2015

GOING TO:

ARTHUR DAVIS

**REDACTED**

FRANKLIN, TN 37068

*use Address  
on Appeals letter*

**YES**

DELIVERY SIGNATURE APPEALS GOING TO EMPLOYEE MUST BE  
SIGNED FOR.



Arthur C Davis Jr  
**REDACTED**  
Spring Hill, TN 37174

April 8, 2014

Aetna Life Insurance Company  
PO Box 14578  
Lexington, KY 40512-4578  
Charlai Lang  
Senior LTD Benefit Manager

Dear Ms. Lang:

I am writing to request a copy of my Aetna Disability file. If it is not possible to receive a copy of my entire file I would like all

Peer Review notes, medical notes and Approval, Termination notes. If you have any questions please contact me at

**REDACTED**

Sincerely,

Arthur C Davis Jr.

**Spears, Barbara Colleen**

---

**From:** Lang, Charlai J  
**Sent:** Tuesday, April 28, 2015 10:49 AM  
**To:** Mailme  
**Subject:** RE: Request for copy of medical file

Yes please send the information to this address, the other address of record is a PO BOX

---

**From:** Mailme  
**Sent:** Tuesday, April 28, 2015 10:45 AM  
**To:** Lang, Charlai J  
**Subject:** RE: Request for copy of medical file

Charlai,

There is a letter in the claim that Mr. Davis sent in to get a copy of his file and he has the address on the letter as REDACTED  
REDACTED Spring Hill, TN 37174. Could you verify if this is a good address to send his claims to so I can send them UPS?

Thanks

Colleen Spears  
Aetna Disability/MailMe  
175 Running Hill Road  
South Portland, Me 04106  
207-791-0630  
[Spearsb2@aetna.com](mailto:Spearsb2@aetna.com)

---

**From:** Lang, Charlai J  
**Sent:** Friday, April 24, 2015 12:04 PM  
**To:** Mailme  
**Subject:** Request for copy of medical file

Arthur Davis

Claim 8893435 and 9452367

Charlai Lang  
LTD Appeals Specialist  
Aetna Life Insurance Company  
Phone: (860) 273-9346  
Fax: 1-855-733-1262

**Spears, Barbara Colleen**

---

**From:** Lang, Charlai J  
**Sent:** Friday, April 24, 2015 12:04 PM  
**To:** Mailme  
**Subject:** Request for copy of medical file  
**Attachments:** Davis 2.docx

**Follow Up Flag:** Follow up  
**Flag Status:** Flagged

**Categories:** APPEALS

Arthur Davis

Claim 8893435 and 9452367

Charlai Lang  
LTD Appeals Specialist  
Aetna Life Insurance Company  
Phone: (860) 273-9346  
Fax: 1-855-733-1262



**PO Box 14560**  
**Lexington, KY 40512-4560**

Phone: 800-354-1779  
Fax: 1-866-667-1987

April 24, 2015

ARTHUR DAVIS  
**REDACTED**  
Franklin TN - 37068

Group Control No: 0476626  
Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

Dear Arthur C Davis:

The Dell Inc Long-Term Disability (LTD) group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna).

We are writing to you regarding your Long-Term Disability (LTD) benefits provided by your employer, Dell Inc, under the above referenced plan.

Per your request, attached is a copy of your file.

If you have any questions, please call 800-354-1779.

Sincerely,

CHARLAI LANG  
Disability Appeals Specialist  
Aetna Life Insurance Company

# - Fax Transmission

**To:** Ms. Charlai Lang

**From:** Nikki Redding, Paralegal

**Fax:** 18557331262

**Date:** 4/28/2015

**RE:** Arthur Davis

**Pages:** 3

---

**Comments:**

Nikki Redding, Paralegal  
Cody Allison & Associates, PLLC  
501 Union St., Suite 502  
Nashville, TN 37219  
Voice: (615) 234-6000  
Fax: (615) 727-0175  
nikki@codyallison.com

THE INFORMATION CONTAINED IN THIS E-MAIL MESSAGE IS PRIVILEGED AND CONFIDENTIAL INFORMATION INTENDED FOR THE USE OF THE ADDRESSEE LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR THE EMPLOYEE OR AGENT RESPONSIBLE FOR DELIVERING THIS MESSAGE TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING, DISTRIBUTION, OR THE TAKING OF ANY ACTION IN RELIANCE ON THE ENCLOSED INFORMATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS E-MAIL IN ERROR, PLEASE CONTACT NIKKI REDDING IMMEDIATELY.



K. Cody Allison, Esq.

501 Union Street, Suite 502  
Nashville, Tennessee 37219  
T. (615) 234-6000  
F. (615) 727-0175  
cody@codyallison.com

April 28, 2015

**CERTIFIED MAIL # 7014 1200 0000 6135 1971**  
**RETURN RECEIPT REQUESTED**

**VIA FACSIMILE: (855) 733-1262**

Ms. Charlai Lang  
c/o Aetna Life Insurance Co.  
P.O. Box 14578  
Lexington, KY 40512-4578

**Re: My Client: Arthur Davis**  
**Claim No.: 9452367**

Dear Ms. Lang:

This firm represents Arthur Davis regarding his denial of his long-term disability benefits through Aetna Life Insurance Company.

I am hereby requesting the following documents on behalf of my client in order to assist in my continuing evaluation of this claim:

1. All plan documents including insurance contracts.
2. A copy of the applicable long term disability insurance policy.
3. Copies of all documents reflecting any and all agreements between the employer and any and all insurance companies, claims administrators and fiduciaries regarding disability insurance policies or plans.
4. Copies of all correspondence to, from and regarding my client, including all claim forms, cover letters, physicians' statements, and other documents.
5. Copies of all medical records, vocational records, rehabilitation records and other documents regarding my client's physical and mental condition, including, but not limited to, all physicians' statements, all reports, testing data and handwritten notes.
6. If this claim has been, or will be reviewed by any medical professional at the carrier or administrator's request, all correspondence to and from the medical professional and all documents reviewed by the medical professional.
7. If this claim has been, or will be reviewed by any vocational professional at the carrier or

administrator's request, all correspondence to and from the vocational professional and all documents reviewed by the vocational professional.

8. My client's job description at the time my client stopped working.
9. Surveillance reports, video and audio tapes, correspondence to and from investigators, and investigative billing information, as well as the un-edited surveillance CDs.

**If there is any charge for copying the documents we have requested, please notify me immediately in writing. If there are any other reasons why you cannot produce the documents we have requested, or if there are any special procedures which must be followed to secure copies of the documents we have requested herein, please advise my office in writing immediately.** A signed authorization form is enclosed for your records.

If you have any questions please let me know.

With kind regards,

CODY ALLISON & ASSOCIATES, PLLC

By: K. Cody Allison, Esq.

KCA/vnr  
Enclosure  
cc: Mr. Arthur Davis

# - Fax Transmission

**To:** Aetna ATTN: Charlai Lang

**From:** Nikki Redding, Paralegal

**Fax:** 18557331262

**Date:** 4/28/2015

**RE:** Arthur Davis

**Pages:** 4

---

**Comments:**

Nikki Redding, Paralegal  
Cody Allison & Associates, PLLC  
501 Union St., Suite 502  
Nashville, TN 37219  
Voice: (615) 234-6000  
Fax: (615) 727-0175  
nikki@codyallison.com

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K. Cody Allison, Esq.

501 Union Street, Suite 502  
Nashville, Tennessee 37219  
T: (615) 234-6000  
F: (615) 727-0175  
cody@codyallison.com

April 28, 2015

Via Fax: (855) 733-1262

Ms. Charlai Lang  
c/o Aetna Life Insurance Co.  
P.O. Box 14578  
Lexington, KY 40512-4578

Re: Our Client: Arthur Davis  
Claim No.: 9452367

Dear Ms. Lang:

My office has been retained to represent Mr. Arthur Davis regarding the denial of his long-term disability benefits.

Mr. Davis has provided me with Aetna's denial letter dated April 24, 2015, at this time, as Mr. Davis' 180 days from the original denial is still not upon us, I would request Aetna open Mr. Davis' claim and allow my office to review his file and also submit additional information for Aetna's review of his claim.

Please advise if Aetna is willing to open the appeal and advise how long Mr. Davis has to submit additional information.

Enclosed you will find executed authorizations allowing my office to communicate as well as receive documentation from Aetna regarding Mr. Davis' claim.

I look forward to hearing from you.

With kind regards,

CODY ALLISON & ASSOCIATES

*K. Cody Allison* / with permission  
By: K. Cody Allison *BK*

KCA/bk  
Enclosures  
cc: Mr. Arthur Davis

**AUTHORIZATION FOR RELEASE OF INFORMATION RELATING TO  
ERISA PLANS AND APPOINTMENT OF REPRESENTATIVE**

**TO: Aetna**

**YOU ARE NOTIFIED THAT** I hereby appoint **CODY ALLISON & ASSOCIATES**, as my attorney to represent me in connection with any and all claims on my behalf relating to my benefit claim, i.e., claim for short-term and/or long-term disability benefits.

**YOU ARE AUTHORIZED AND REQUESTED** to release to my attorney, **CODY ALLISON & ASSOCIATES**, 501 Union Street, Suite # 502, The Union Building, Nashville, TN 37219, any coping service acting pursuant to this authorization, any and all documents and other items relevant this claim including, but not limited to, plan modifications, any and all documents contained in my personnel file and/or my benefit claim file including, but not limited to, any and all medical records, including admission notes, medical history sheets, test results, x-rays, and any and all other records in your possession relating to my claim, inclusive of salary information and other documents relating to offset of benefits/coordination of benefits with social security (if this is a disability claim), as well as notes and comments made by claim reviewers.

The undersigned releases you or anyone working on your behalf from any privilege, right, or liability which you may have in said records.

This authorization shall remain in effect from the date below until revoked: and the request made herein shall be deemed continuing.

**Date:**

4/24/15

  
\_\_\_\_\_  
**CLIENT**

**REDACTED**

\_\_\_\_\_  
**SOCIAL SECURITY NUMBER**

**REDACTED**

\_\_\_\_\_  
**DATE OF BIRTH**

29 U.S.C. § 11321(C) provides:

Any administrator who fails or refuses to comply with a request for any information which such administrator is required by this sub chapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary in the amount of up to \$110 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

**AUTHORIZATION TO COMMUNICATE WITH  
CODY ALLISON & ASSOCIATES, PLLC**

I, Arthur Davis, hereby authorize any administrator, fiduciary, governmental entity, insurance company, or other individual or company to communicate with my attorney and representatives of my attorney.

**CODY ALLISON & ASSOCIATES, PLLC**

501 Union Street, Suite # 502

The Union Building

Nashville, TN 37219

Phone: (615) 234-6000

Fax: (615) 727-0175

Arthur Davis  
CLIENT'S SIGNATURE

4/24/15  
DATE

Arthur Davis  
CLIENT'S PRINTED/TYPED NAME

**REDACTED**  
SOCIAL SECURITY NUMBER

Arthur C Davis Jr

REDACTED

Spring Hill, TN 37174

April 8, 2014

Aetna Life Insurance Company  
PO Box 14578  
Lexington, KY 40512-4578  
Charlai Lang  
Senior LTD Benefit Manager

Dear Ms. Lang:

I am writing to request a copy of my Aetna Disability file. If it is not possible to receive a copy of my entire file I would like all

Peer Review notes, medical notes and Approval, Termination notes. If you have any questions please contact me at

REDACTED

Sincerely,

Arthur C Davis Jr.

*Arthur C Davis Jr*

REDACTED

Spring Hill, TN 37174

April 8, 2014

Aetna Life Insurance Company  
PO Box 14578  
Lexington, KY 40512-4578  
Charlai Lang  
Senior LTD Benefit Manager

Dear Ms. Lang:

I am writing to request a copy of my Aetna Disability file. If it is not possible to receive a copy of my entire file I would like all

Peer Review notes, medical notes and Approval. Termination notes. If you have any questions please contact me at

REDACTED

Sincerely,

  
Arthur C Davis Jr.

To Charlai Law 6

From: Arthur C. Davis Jr

6 pgs

1



PO Box 14578  
Lexington, KY 40512-4578  
CHARLAI LANG  
SENIOR LTD BENEFIT MANAGER  
Phone: 800-354-1779  
Fax: 1-855-733-1262

March 4, 2015

ARTHUR DAVIS

**REDACTED**

Franklin TN - 37068

20150005802 JASC  
J01114A  
[QR]

Dear Arthur C Davis:

**Your request is in process**

We're reviewing your appeal that was received on January 22, 2015 for your Long-Term Disability (LTD) claim (claim # 9452367), but we need more time because your file was sent for a specialty matched medical opinion, and we are currently awaiting the report from that peer review.

Given this reason we'll need a forty-five (45) day extension to complete the appeal review. We hope to be able to make a decision before April 22, 2015, but we'll try to complete the review prior to that date.

**We're here to help you**

It's important that you keep a copy of this letter for your records. For questions about this letter or your claim, you can call me at 800-354-1779.

Sincerely,

CHARLAI LANG  
SENIOR LTD BENEFIT MANAGER  
Aetna Life Insurance Company

000187-201114A000187(1)

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**PINNACLE**  
Surgical Partners

**PHYSICAL THERAPY**  
Prescription for Shoulder

**SEAN B. KAMINSKY, MD**

at Summit Medical Center  
5653 Frist Boulevard, Suite 731  
Hermitage, TN 37076  
Telephone (615) 885-2778  
Fax (615) 936-6032

Name: Arthur Davis Date: 3/31/15  
Diagnosis: RASS2UG ROT  
Procedure: SAD/RCR  
Date of Surgery: 3-25-15 Side: ☒ Right ☐ Left  
Frequency: ☐ One Visit ☐ QW ☐ BIW ☒ TIW ☐ QIW ☐ PRN  
Duration: ☐ One Visit ☐ Weeks ☒ Months ☐ PRN  
Home Program: ☒ Yes ☐ No  
Send instructions to therapist in hometown? ☐ Yes ☒ No

**Exercises**

- ☒ Pendulum
- ☒ Hand/Elbow
- ☒ Warm up exercises
- ☒ Passive forward elevation (scapular plane with assistance)
- ☐ Pulley (when achieved 120° passive FE)
- ☒ Passive external rotation \_\_\_\_\_ ° maximum
- ☐ Active assisted forward elevation (scapular plane) sitting/supine
- ☐ Active assisted internal rotation
- ☐ Active forward elevation (scapular plane)
- ☐ Isometrics
- ☐ Theraband (color: \_\_\_\_\_) IR ER AD
- ☐ Dumbbell exercises \_\_\_\_\_ lb. maximum
- ☐ Posterior capsular stretching
- ☐ Scapular exercises
- ☐ Plyometrics
- ☐ Throwing interval program
- ☐ Advanced overhead strengthening as tolerated
- ☒ Therapool exercises: Phase I Phase II
- ☐ Cervical mobilization
- ☐ Cervical strengthening
- ☐ Cardiovascular fitness program
- ☐ Lower extremity strengthening
- ☐ Functional capacity evaluation

**Modalities**

- ☐ Ice
- ☐ Heat
- ☐ Alternate ice/heat
- ☐ Phoresis (ionto, phono)
- ☐ Electric stimulation (office, home)
- ☐ Stockinette UE to reduce swelling
- ☐ Massage
- ☐ Wound care
- ☒ PRN

**Precautions**

- ☒ No active motion
- ☐ Avoid abduction
- ☐ No abduction with external rotation
- ☐ Avoid prone exercises
- ☒ Stretch to pain tolerance only
- ☐ Only exercise with assistance

**Goals Detailed in Therapist Evaluation**

- ☐ Increase strength
- ☐ Decrease pain
- ☐ Increase exercise program
- ☐ Increase endurance
- ☐ Increase ROM
- ☐ Prevent joint contractures
- ☐ Return to full function
- ☐ Work hardening
- ☐ Work conditioning

I certify the medical necessity of services furnished under this plan of care.

Physician signature: \_\_\_\_\_ Date: 3/31/15



**Summit Surgery Center**  
3901 Central Pike Ste 152  
Hermitage, TN 37076

**Operative Report**

**Name:** Davis, Arthur  
**Case Number:** 48591  
**Physician:** Sean Kaminsky, M.D.

**Date:** 03/25/2015  
**DOB:** REDACTED

**PREOPERATIVE DIAGNOSES:**

1. Right shoulder recurrent massive rotator cuff tear.
2. Right shoulder impingement syndrome.
3. Right shoulder acromioclavicular arthrosis.
4. Right shoulder glenohumeral synovitis.

**POSTOPERATIVE DIAGNOSES:**

1. Right shoulder recurrent massive rotator cuff tear.
2. Right shoulder impingement syndrome.
3. Right shoulder acromioclavicular arthrosis.
4. Right shoulder glenohumeral synovitis.
5. Right shoulder loose, foreign body.

**PROCEDURES PERFORMED:**

1. Right shoulder arthroscopy, arthroscopic loose foreign body removal.
2. Right shoulder arthroscopic complete glenohumeral synovectomy.
3. Right shoulder arthroscopic subacromial decompression.
4. Right shoulder arthroscopic distal clavicle excision.
5. Right shoulder arthroscopic revision rotator cuff repair.

**SURGEON:**  
Sean Kaminsky, M.D.

**COMPLICATIONS:**  
None.

**ANESTHESIA:**  
General endotracheal anesthesia plus scalene.

**ESTIMATED BLOOD LOSS:**  
Minimal.

**INDICATIONS:**

Mr. Arthur Davis is a 51-year-old gentleman with complaints of ongoing right shoulder pain and weakness despite previous surgery. His preoperative MRI study from 03/02/2015 demonstrated massive recurrent tearing of the supraspinatus and infraspinatus tendon with extraction. He was indicated for right shoulder revision arthroscopy after risks, benefits, and options were discussed preoperatively.

**DESCRIPTION OF PROCEDURE:**



**Summit Surgery Center**  
3901 Central Pike Ste 152  
Hermitage, TN 37076

**Operative Report**

**Name:** Davis, Arthur  
**Case Number:** 48591  
**Physician:** Sean Kaminsky, M.D.

**Date:** 03/25/2015  
**DOB:** REDACTED

The patient was brought to main operating room and placed in supine position where he was intubated by Anesthetic Team and transferred to a 50-degree beachchair position. All body prominences were padded and the patient received preoperative antibiotics. His neck was maintained in neutral flexion and extension and rotation throughout the procedure. The right upper extremity was prepped and draped in a typical sterile fashion after preoperative time-out was taken to identify the correct extremity.

A posterior portal was established and a 30-degree arthroscope was introduced atraumatically into the glenohumeral joint space. A complete diagnostic arthroscopy was performed demonstrating moderate synovitis throughout the glenohumeral joint space. Small partial thickness tear of the biceps tendon was noted less than 20% thickness of the tendon. Synovitis extended into the biceps labrum, articular and capsular. Massive tearing of the supraspinatus and infraspinatus tendons was noted. The articular surface of the glenohumerus demonstrated mild chondromalacia, but otherwise intact. The arthroscopic instrument was withdrawn and redirected to the subacromial space and an anterior portal was established. A 4.0 mm shaver was introduced and completed synovectomy was performed. The synovitis was debrided along the labrum circumferentially with capsule and biceps tendon. This provided improved appearance upon completion. The arthroscopic instrument was then withdrawn and redirected to the subacromial space.

An anterior inflow portal was established with a Wissinger rod and a lateral portal was then established. A 4.0 mm shaver was introduced. The biceps tendon tearing was gently debrided. The massive tearing of the rotator cuff was noted. Residual sutures were noted embedded in the humeral head extending into glenohumeral joint. These were removed arthroscopically using grasper. Extensive massive tearing of the supraspinatus and infraspinatus tendons was again noted with retraction nearly to the level of the glenoid margin. Extensive adhesions and fibrosis were noted on the intra and extraarticular surfaces. The undersurface of the acromion was then developed. The acromial spur was then sharply removed using a 4.0 mm barrel bur and decompression completed. Lysis of adhesions was performed throughout the subacromial and subdeltoid region to assist in immobilization of this fibrotic rotator cuff. Tissue thinning and retraction was noted with significant loss of tissue quality. Intra and extraarticular adhesions were again lysed and immobilization was improved. Immobilization of the tissues was performed until the rotator cuff could reach the immediate greater tuberosity. The greater tuberosity was debrided in preparation for repair. The arthroscope was switched to lateral portal and anterior-posterior cannula was established. Margin convergent suture pattern was then undertaken from medial to lateral. Using Linvatec crescent suture passers and shuttle relay in addition to angle penetrating suture grasper, #2 Hi-Fi sutures were then placed. The apex of the suture is then progressing laterally until the rotator cuff reached to the level of the medial greater tuberosity. A Cayenne Quattro X 5.5 mm anchor was then placed at the medial aspect of the greater tuberosity. #2 Hi-Fi sutures here were then passed through the anterior-posterior leaflets respectively using a combination of passing suture instruments. The sutures were retrieved in pairs and tied and cut. This substantially provided improved appearance of the rotator cuff although again repair could be continued onto the level of the medial marking of the



**Summit Surgery Center**  
3901 Central Pike Ste 152  
Hermitage, TN 37076

**Operative Report**

**Name:** Davis, Arthur  
**Case Number:** 48591  
**Physician:** Sean Kaminsky, M.D.

**Date:** 03/25/2015  
**DOB:** REDACTED

greater tuberosity with massive tear. With the arthroscope in the lateral portal, a 90-degree Vapir was introduced in the acromioclavicular joint. The acromioclavicular joint was then developed demonstrating arthritic changes. Using a 4.0 mm barrel bur, the distal clavicle excision of approximately 1 cm was performed under direct arthroscopic visualization. Smooth resection of the distal clavicle was performed. The arthroscopic instrument was then withdrawn. The portal sites were re-approximated. Dry sterile dressing was applied to the upper extremity. The upper extremity was placed in abduction external rotation control brace. He was then transferred to the hospital bed in recovery room in awake and in stable condition. Sponge and needle counts were correct. There were no obvious intraoperative complications.



Sean Kaminsky, M.D.

532384/SK/med: lms/ppc  
DD: 03/25/2015 06:43 hrs.  
DT: 03/26/2015 05:17 hrs.

6



## Fax Message

---

**To:** Aetna Disability Appeals

**Fax:** 855-733-1262

**From:** Lang, Charlai J

**Date:** 3/20/2015 3:19 PM

**Pages:** 1 of 12 (including this page)

**Subject:**

---

**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Charlai Lang  
Senior LTD Appeals Specialist  
Aetna Life Insurance Company  
Phone: (860) 273-9346  
Fax: 1-855-733-1262

**Lang, Charlai J**

---

**From:** ARCS Physician Review  
**Sent:** Monday, March 16, 2015 3:33 PM  
**To:** Lang, Charlai J  
**Subject:** [SEND SECURE] COMPLETED PHYSICIAN REVIEW  
**Attachments:** Davis Arthur 99927 - Cirincione08-03876866.pdf

**WORKABILITY CENTRALIZED DOCUMENTS**

**Account Name: Office Depot Dell**

**Batched By:**

**Date: 3/20/15**

**Claimant's Name: Arthur Davis**

**SSN: REDACTED**

**Claim #: 9452367**

\*\*\*\*\*

**Index the document as Peer Review & assign it to**

---

\*\*\*\*\*



## Physician Review

### CLAIM DATA

**ID Number:** 99927

**Last Name:** DAVIS

**DOB:** REDACTED

**Claim Number:** 9452367

**First Date of Absence:** 10/09/2013

**Claim Type:** LTD

**Disability Test:** OWN OCC

**First Name:** ARTHUR

**Employer:** Dell Inc

**Insurance Carrier:** Insured, AETNA

**Occupation/Job Title:** INSIDE SALES ACCOUNT  
MGMT III

**Physical Demand Rating:** Sedentary

**Specific Vocational Preparation (SVP) Rating:** N/A

**Prior Reviewer(s):**

**Diagnosis(es):** 782.0 - DISTURBANCE OF SKIN SENSATION

### REFERRAL INFORMATION

**Last Name:** LANG

**E-mail contact:** [langc2@Aetna.com](mailto:langc2@Aetna.com)

**Requester's Phone Number:** 9346

**Claim Office:** None Listed

**Submission Date:** 03/05/2015

**Appeal:** YES

**Addendum:** NO

**Telephonic Consultation with Provider Requested:** YES

**Specialty Requested:** Orthopedic Surgery

**First Name:** CHARLAI

**Extension:**

**Perfection Date:**

### PROVIDER CONTACT INFORMATION

**Treating Provider's Name (1):** Buechel, Paul

**Treating Provider's Specialty (1):** Neurology

**Phone Number:** 615-550-1800

**Time Zone:** Eastern Time

**Treating Provider's Name (2):** Green, Brenna

**Treating Provider's Specialty (2):** Physical Med && Rehab/Pain Management

**Phone Number:** 615-867-7971

**Time Zone:** Eastern Time

**Treating Provider's Name (3):** RENFRO, JAMES

**Treating Provider's Specialty (3):** Orthopedic Surgery

**Phone Number:** 615-834-4482

**Time Zone:** Eastern Time

### REVIEWING PHYSICIAN DATA

**Reviewer Assigned:** CIRINCIONE, MD, ROBERT

**Specialty Assigned:** Orthopedic Surgery

**Assignment Date:** 03/05/2015

**Additional peer review requested from the following specialist:**

### CLAIM SYNOPSIS:

EE is a 51 year old male inside sales account manager who went oow effective 10-09-13 due to left massive rotator cuff tear and bicep tendon attrition. EE had repair on 10-11-13 and was advised out of work through 1-

Davis



14-14 with post-surgical tx of physical therapy and pain medication. Medical support through 1-15-15 and ee was found to have sedentary work capacity.

#### RECORDS SUBMITTED FOR REVIEW:

Image 16830010 appeal request form  
 Image 16831071 page two appeal request form Ovn dated 1/20/15 Dr. Buechel  
 Image 16769991 appeal from ee dated 1/21/15  
 Image 16538935 ovn dated 10/16/14 12/02/2014 Dr. Buechel MRI 12/17/14 and 11/08/14  
 Image 15695031 ovn dated 7/14/14 Dr. Yoneyama attending physician statement dated 6/20/14 Dr. Yoneyama  
 Image 15444211 page 2 and 3 of ovn Jason Knox DBM  
 Image 15319999 medication list  
 Image 15354989 attending physician statement dated 6/25/14 Dr. Prasad  
 Image 15298734 Ovn note dated by signed by Dr. Green DO on 4/22/14 and 5/6/14  
 Image 15027398 ovn dated 4/25/2014 operative report dated 4/18/14  
 Image 15004343 Peer Review dated 4/14/14  
 Image 14692980 2/25/14 3/6/14 3/12/14 PT notes Jason Barclay  
 Image 14692906 1/31/14 2/11/14 PT notes  
 Image 14689376 MRI Lumbar 11/6/13, ovn dated 12/9/13 1/28/14 Dr. Kauffman ovn dated 1/16/14  
 psychotherapy dated 1/20/15 ovn dated 3/4/15 3/10/15 3/6/14  
 Image 14704198 physical therapy notes 3/4/14 3/13/14 3/18/14 PT note dated 10/22/13 through 3/20/14  
 Image 14724386 Ovn dated 1/16/15 1/28/14 3/16/14 Dr. Cote  
 Image 14638533 Attending Physician Statement dated 2/28/14 Dr. Renfro  
 Image 14638525 capabilities form dated 3/11/14  
 Image 14547889 Attending Physician Statement dated 3/11/14  
 Image 14389252 Operative Report dated 1/31/14 Dr. Renfro  
 Image 13914662 Attending Physician Statement 11/15/13 Dr. Renfro  
 Image 13711699 Work status report dated 10/15/13 Dr. Renfro  
 Image 13702950 10/7/13 renfro shoulder MRI dated 10/1/13 operative report dated 10/11/13 Dr. Renfro  
 Image 13698583 Fitness for Duty dated 10/14/13 Dr. Renfro  
 Image 13698586 Attending Physician Statement dated 10/4/13 Dr. Renfro

#### CLINICAL FILE REVIEW:

**I have reviewed all of the records listed above. I will directly comment upon information most relevant to the question(s) posed and the time period(s) in question.**

I have been asked to review the medical records and speak with the claimant's multiple treating providers. I have been asked to determine whether or not the medical data demonstrates the employee's inability to maintain sedentary work capacity from 10/9/13 to 6/30/15.

I have medical records. I have a previous Aetna Physician Review completed by Dr. Rubin on 4/14/14. I have reviewed other records, included in that is an Aetna Long-Term Disability Appeal signed by Mr. Davis. This is dated 1/21/15. He notes back pain. His medications include doxepin 25 mg and 900 mg of Gralise. He says he is drowsy all the time and has difficulty functioning. He describes burning sensation. He describes issues with his shoulder. He notes he has had recurrent problems with his shoulder.

I have records from Dr. Renfro dated 10/7/13. At that time the claimant was evaluated for bilateral shoulder pain. He had a long history of shoulder pain which has been progressive. His pain was rated 10/10 at that time.

Davis

He had an MRI prior to the evaluation which revealed a massive rotator cuff tear. The date of the MRI was 10/1/13. He did not have fatty infiltration, but appears to be more of an acute, un-chronic type tear. Surgery was scheduled for repair of the left rotator cuff tendon rupture. I have the operative note of 10/11/13 where the claimant underwent an open rotator cuff repair including a decompression as well as a biceps tenodesis. The claimant was seen in follow up by Dr. Renfro. Initially, he was restricted from using the left arm in the postoperative period. On 2/28/14 I have an Attending Physician Statement indicating that the claimant had also undergone a right rotator cuff repair. He was advised not to use either upper extremity. He had decreased motion in his shoulder.

I have the operative note from 1/31/14 where he underwent a repair of a massive right rotator cuff tendon rupture. He underwent an open rotator cuff repair of the right shoulder, excision of the distal clavicle of the right shoulder, and a subacromial bursa debridement and subacromial decompression. Again, the surgery on the right shoulder was 1/31/14. On 4/14/14 the claimant underwent a partial medial and lateral meniscectomy of his left knee. This was performed by Dr. Renfro.

I have follow up records on 4/25/14 Dr. Renfro saw the claimant again. He had slight swelling in the knee. He was in therapy for his shoulders and "doing well." He simply needs more strengthening to the shoulder. Light strengthening exercises were discussed.

He also carries a diagnosis of depression, according to Dr. Renfro's note 4/25/14.

An MRI of the claimant's low back was performed on 11/6/13. It revealed multilevel disk bulges. No spinal stenosis was noted. There was multilevel facet joint ligamentum flavum hypertrophy with mild right neuroforaminal narrowing at L4-L5 and mild left neuroforaminal narrowing at L5-S1. There was mild degenerative disk disease at L3-L4.

The claimant was seen by Dr. Christopher Kauffman on 12/19/13. The claimant stated his low back pain began on 9/27/13. It had a sharp and shooting quality. His pain radiated into the right posterior leg nonspecific and lower part of the leg also in a nonspecific fashion. The pain is described as being constant. He said the pain began with a motor vehicle accident. The pain is described as maximal at night.

The claimant says that he had been treated with a course of physical therapy and nonsteroidal antiinflammatory pain medication and bedrest. He said the physical therapy was partially effective in relieving his pain. The MRI was reviewed. The claimant reported that his back pain had stabilized. The claimant reports his main pain has been back pain at night. Neurontin was suggested. He had no history of back surgery. His clinical examination revealed mild reduced range of motion in the lumbar spine, normal strength, normal muscle tone, straight leg raising was negative bilaterally. Examination of the lower extremities revealed normal strength, normal reflexes, normal pulses, and the sensation in the lower extremities was intact. The claimant was diagnosed by Dr. Kauffman with degeneration of the lumbar intervertebral disk and lumbago. He was referred to physical therapy. He was suggested to begin gabapentin. It was felt that he had low back pain secondary to degenerative changes and facet arthropathy. He was advised to return as needed.

On 1/16/14 the claimant was seen by Dr. Cote. He had left rotator cuff surgery in October of 2013. He noted that he had torn both of his rotator cuffs. He said he was in a motor vehicle accident on 9/27/13 and that he was hit from behind. He said that accident exacerbated his chronic low back pain. He said he just has to "deal with" the back pain with yoga and stretching. He had taken multiple pain medications in the past which did not work. His pain is most often occurring at night. His medications at that time included Advair, Celebrex, potassium chloride, and lisinopril. Physical examination revealed no neurologic deficits. He had normal strength and sensation. He was diagnosed with low back, benign essential hypertension, esophageal reflux, intervertebral

Davis

disk degeneration, and somatic dysfunction of the sacroiliac region. Plan for the low back, it was felt that the claimant's pain at that time was adequate. No changes in medication management were suggested. Physical therapy again was discussed.

On 1/28/14 the claimant again was seen by Dr. Cote. Again, he was seen for follow up of his motor vehicle accident. Physical therapy has not been helpful.

He said he was feeling "down." He denied feeling depression.

His clinical examination at that time again revealed no specific neurologic deficits.

I have a report of physical therapy from Results Physical Therapy. The claimant was seen on 1/20/14. He complained of low back pain, sacral pain impacting his work, sitting, standing.

His range of motion extension was limited to 50%, flexion 75%, side bending to the left 75%, side bending to the right 75% which aggravated his discomfort. He had severe pain to palpation over the gluteus maximus, piriformis, quadratus lumborum on the right and left.

He was begun in therapy to evaluate and improve the subjective complaints.

I have the follow up evaluation notes. He was in therapy for several visits.

He complained of "burning" in his low back on 1/23/14. He continued to be seen and evaluated. He was seen for exercises, manual therapy techniques, and electrical stim.

He continued to be seen and evaluated. He was working on his range of motion and strengthening during these visits. He had subjective complaints of pain with increased range of motion exercises.

On 2/7/14 he was reevaluated. His objective examination at that time revealed mild tenderness in the gluteus maximus, piriformis, and quadratus lumborum. His range of motion was now 100%.

The claimant was noted to be "progressing well towards goals objectively with improved sitting time and improved exercise tolerance." The claimant continued to complain of pain with sitting but is able to sit longer before position change. The claimant was clipped in a shoulder sling. The claimant had no complaints of pain after his evaluation. This is a note from Lakota Hillis, PT.

The claimant continued to be seen and evaluated at Results. On 2/10/14 the claimant said he could sit eight minutes before he had to change position.

He continued to be evaluated at Results. On 2/14/14 he was evaluated again at results. His pain level at this time was now 0/10.

On 7/14/14 the claimant was seen by Dr. Yoneyama. His low back pain was radiating down his legs at a level of 6/10. He describes with burning, intermittent, bee sting type pain. He started Cymbalta, but the claimant said that caused tingling in his leg. His neck and low back pain was not relieved by Aleve. He said he is exercising on a treadmill one hour a day and takes Tylenol. His weight has gone from 260 to 240 pounds. He notes some mood swings.

His medications included omeprazole, Celebrex, Zyrtec, Flonase, Advair, lisinopril, clonidine, diazepam,  
Davis

spironolactone.

His BMI at that point was 33.36. His clinical examination was reviewed. The neurologic examination, claimant was noted to be awake and alert with no impairment of recent or remote memory.

Musculoskeletal examination and related system was normal.

Peripheral vascular examination was normal. The claimant was felt to have paresthesias. He said he had burning all day. He was scheduled for an EMG on 6/13/14. He had no weakness or numbness. He was taking Lyrica. He was referred back to neurology.

I have notes from Dr. Buechel. The claimant was seen on 10/16/14. He presented for evaluation of back pain. He said his symptoms were better with medication. The claimant said the aggravating factors included exertion and movement in general.

His episodes of pain are variable. He was complaining of pain in his right and left feet and ankles. It was described as burning in nature.

The claimant states he underwent epidural steroid injection at Dr. Green's office with only 24 hours of relief. He has seen Dr. Cote in the past and a podiatrist, Dr. Knox. A Dr. Prasad on 5/14/14 did an EMG. The claimant was told by Dr. Prasad that "he couldn't help." Clinical examination was recorded. His neurologic examination was noted to reveal normal motor strength. He had no tremor. Reflexes were symmetrical and intact in the upper and lower extremity. He had reduced sensation in the right L4 and S1 dermatomes to sharp sensation. Psychiatric evaluation was normal. It was felt by Dr. Buechel that the claimant's back pain was musculoskeletal in nature. He was advised to use daily stretching and workouts five days a week. It was felt he may have an element of causalgia for the neuropathic pain and Cymbalta was recommended.

Dr. Buechel said he would try to evaluate the EMG studies personally.

On 12/2/14 the claimant was followed for "causalgia of lower limbs." Symptoms are better. He was seen for a follow up of his diagnosed lumbar radiculopathy.

He was evaluated on that date. Again, his clinical examination was unchanged. He was referred again to PT.

A repeat MRI was performed on 11/6/14. This was requested by Dr. Buechel at Premier Radiology in Cool Springs. This claimant was noted on study to have scattered lumbar degenerative and stenotic findings. He did not have "more than mild stenosis at any level." He also was noted to have degenerative changes at T10 to T11 which were incompletely evaluated. On 1/23/15 the claimant was seen again by Dr. Buechel. The claimant continued to have back pain. He said he could not sit for more than ten to 15 minutes. He could not sleep. He was taking doxepin which helped the claimant sleep. He said if he takes it he cannot wake up. He said symptoms are worse with exertion and movement in general. His clinical examination again revealed normal neurologic examination except for reduced sensation right L4 and S1 dermatomes. He was tender over L4 to S1.

It was felt by Dr. Buechel that the claimant could not sit at a ten-hour job. His medications were increased. Referral to pain management clinic was discussed.

I have records from Dr. Green. On 4/24/14 the claimant was seen for lumbar disk disease. The claimant underwent a coccygeal injection on that date by Dr. Green.

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On 5/6/14 the claimant was again seen by Dr. Green. He had chronic pain. He also discussed his left knee issues which he felt were feeling better. The MRI was discussed. It revealed degenerative disk disease at L4-L5, L5-S1 with facet arthropathy. He said he had back pain 20 years before. He notes the shoulder surgery. At that time in May of 2014 he was taking oxycodone and tramadol.

His clinical examination is noted that he was able to transfer and ambulate independently. Motor testing revealed functional motor strength in the lower extremities without focal deficit. Reflexes were symmetrical with depression of the ankle reflex. Straight leg raising was negative, and there was no ataxia noted.

Physical therapy was suggested. An FCE was mentioned. An EMG was discussed. Lumbar medial branch blocks were discussed.

I have physical therapy notes from Star PT which the claimant was seen initially on 10/22/13. He had upper extremity and lower extremity issues.

He was in Star PT for many months. At some times his condition would improve. On 10/23/13 he said he felt better after therapy. He was seen in therapy at Star following his rotator cuff repair. On 11/11/13 he said he was "just ignoring" his low back pain. He continued to work on his left shoulder. He continued to be seen and followed on a periodic basis for his left shoulder. On 11/25/13 he said his low back was stiff and hurting. He did his exercises that morning, but he still had discomfort. He continued to be seen and evaluated at Star PT. He continued to have more low back pain symptoms. On 12/10/13 he was going to a spin class at that time. He had soreness and could not lift his arm above shoulder height on 12/13/13. He continued to be seen and followed. He was evaluated on 1/9/14. At that time he had more low back pain. He was doing a home exercise program for his left shoulder, and he was felt to be progressing. He continued to be seen at Star. I have reviewed the notes from 1/30/14. At that time his shoulder range of motion continued to improve in strength and decreased pain. He was compliant with his home exercises.

On 2/18/14 his left shoulder was stable. No significant change in pain. He was able to regain some more extension and rotation in his shoulder at that visit. On 2/21/14 he discussed his pending surgeries on his right shoulder. On 2/25/14 his right shoulder felt pretty good. He continued with Star Physical Therapy. He said his left upper extremity was getting stronger on 3/11/14. He had crepitus in his shoulder on 4/25/14. He said his doctor was concerned about the "noise" in his shoulder.

#### **PEER-TO-PEER CONSULTATION:**

I was asked to speak with the claimant's treating providers. I spoke with Dr. Buechel on 3/11/15. Dr. Buechel and I discussed the claimant's condition. He said he last saw the claimant three months ago. The claimant complained of back pain. Dr. Buechel said that there was difficulty getting control of the claimant's back pain. Dr. Buechel referred him to a neurosurgeon. I asked Dr. Buechel if there were any objective findings on the clinical examination that he could correlate the claimant's subjective complaints of back pain, and he said there really was "nothing dramatic on examination." Dr. Buechel also noted there was no muscle spasm.

Dr. Buechel had no specific comments regarding the claimant's work ability.

I spoke with Dr. Green on 3/12/15. Dr. Green noted that the claimant had back pain and complained of pain with activity. There were no specific neurologic findings. The claimant had subjective complaints of pain and had been treated with injections. No specific motor deficits were documented.

Davis

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I spoke with Dr. Renfro on 3/12/15. Dr. Renfro noted that the claimant had massive rotator cuff ruptures in both the left and right shoulder. He notes on recent evaluation the claimant has a recurrent tear of the left rotator cuff tendon. At this time the MRI of the left shoulder reveals fatty infiltration in the supraspinatus and infraspinatus muscles. The fatty infiltrate indicates the tear now is irreparable. Dr. Renfro has referred the claimant for a second opinion and a discussion of possible shoulder replacement has been made. Dr. Renfro said he will probably send the claimant for another evaluation prior to determination of surgical intervention. We discussed whether the claimant could work. He felt the claimant was able to do sedentary duties lifting no more than five pounds and no reaching at or above shoulder height.

I spoke with Dr. Yoneyama on 3/13/15. Dr. Yoneyama stated that the claimant had severe back pain. He also noted he felt the claimant had neuropathic pain. He noted that the claimant should not work. Dr. Yoneyama specifically said that "I can support his not working during the time frame from October of 2013 to March of 2015.

### **REFERRAL QUESTIONS & CONCLUSIONS:**

1.) Based on the available records and any telephonic consultations, please provide your assessment and detailed clinical correlation for any functional impairment, as well as the time periods that they exist. From 10/9/13 to 6/30/15

Based on the available records and telephonic consultation, I have been asked to provide my assessment and detailed clinical correlation for any functional impairment as well as the time periods they exist.

Based on the medical records and the telephonic consultation regarding the claimant upper extremities, the medical records and teleconference I had with Dr. Renfro supports a functional impairment involving the claimant's bilateral upper extremities which includes a repaired right rotator cuff and a recurrent massive left rotator cuff tendon rupture. The left rotator cuff tear is not reparable. These findings support a functional impairment in both upper extremities which would support the claimant being unable to lift greater than five pounds or do any lifting above shoulder height. The claimant should be restricted to work below shoulder height and limit lifting, pushing, pulling to five pounds or less with both upper extremities.

Regarding the claimant's low back pain, the claimant has been seen by Dr. Buechel, Dr. Green, Dr. Yoneyama, and Dr. Cote in addition to other physicians. The claimant has undergone diagnostic studies including MRIs and an EMG. I do not have the reports of the EMG. The claimant carries several diagnoses in addition to the degenerative disk disease. The claimant has diagnosis of causalgia according to the medical records. Causalgia is an abnormal response to pain and stimulus. The exact cause of causalgia is unknown. However, it presents with objective findings including coolness of the extremity, hypersensitivity to touch, edema, loss of active motion as well as hair and nail changes. These findings were noted on the clinical examination, and therefore the diagnosis of causalgia is not supported.

The claimant has chronic low back pain which he relates to a motor vehicle accident in 2013. He also notes a history of low back pain going back 20 years according to the medical records. At this time he has subjective complaints of back pain. Dr. Yoneyama discussed "neuropathic pain." Again, a neuropathy has not been documented in the clinical records I have been able to review. Most of the clinical examination reveal a normal sensory motor examination. Dr. Cote noted decreased sensation in L4 and S1 only. The physicians, Dr. Yoneyama and Dr. Green suggested the claimant be off work due to his subjective complaints of back and leg pain. However, the medical records and examination findings do not correlate with the objective findings. Therefore, based on a complete review of the medical records and the clinical examination, the objective

Davis



findings do not support the employee's inability to maintain a sedentary work capacity. Dates are 10/9/13 to 6/30/15. During that period of time the claimant travelled to multiple physical therapy visits and multiple physician visits. During that time the claimant engaged in home exercise programs as well as was enrolled in a spinning class. These activities support the opinion that the claimant would have been able to maintain a sedentary work capacity from 10/9/13 to 6/30/15.

2.) Does the medical data demonstrate ee's inability to maintain a sedentary work capacity? Please see answer to Question #1.

The opinion above is based on the information available for review and held to a reasonable degree of clinical certainty. I certify that I have no relationship or affiliation with the claimant whose claim is the subject of this independent review, nor a significant relationship with the treating provider(s) and/or the treatment facility. I further certify that I have no familial or material professional or business relationship, nor incentive to promote the use of any services which may be associated with the claim that is the subject of this review, nor do I have any incentive, financial or otherwise, that would lead me to offer an opinion other than based on my honest professional assessment of the information provided for review.

Robert Cirincione, M.D. 3.16.15  
Board Certified in Orthopedic Surgery

**Confidential**

This report is confidential and should be read only by designated Aetna Disability and Leave Management Services staff or specific designees in accordance with the Aetna Code of Conduct and applicable law.

**Consult Level: Level Three**

Dictated On: 3/15/15  
Transcribed On: 3/15/15 LB Job#: 08-03876866  
AA 3/16/15 - D

Davis

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PO Box 14578  
Lexington, KY 40512-4578  
CANDICE HOY  
Appeal Assistant  
Phone: 800-354-1779  
Fax: 1-855-733-1262

January 29, 2015

ARTHUR DAVIS

**REDACTED**

Franklin TN 37068

Dear Arthur Davis:

**Good news - your request is in process**

We received your appeal request for your Long-Term Disability (LTD) claim (**claim # 9452367**) on January 22, 2015. We attached two forms for you to complete to help us obtain some additional information. If you don't complete them, we'll still process your appeal. When your case is assigned to an Appeal Specialist, that person may be contacting you to obtain additional information on your appeal.

**Let's work together**

If you plan to send more information to support your appeal:

- Call us as soon as possible to let us know, and;
- Send us the information, so we can consider it during our review

Please mail or fax the additional information to:

Aetna Life Insurance Company  
PO Box 14578  
Lexington, KY 40512-4578  
Fax: 1-855-733-1262

**We're here to help you**

It's important that you keep a copy of this letter for your records. For questions about this letter or your appeal, you can call us at **800-354-1779**.

Sincerely,

Candice Hoy  
Appeal Assistant  
Aetna Life Insurance Company

**Enclosures:**

Authorization to Request Protected Health Information  
Disability Appeal Request Form

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*Arthur C Davis, Jr*

REDACTED

Spring Hill, TN 37174

March 6, 2015

Aetna Insurance  
Charlai Lang Senior LTD Appeals Specialist  
Claim#9452367

Dear Ms. Lang,

I am faxing my Shoulder MRI dated March 2<sup>nd</sup> 2015. The MRI clearly shows a renewed Massive rotator cuff with the additional issues of retracted tendons. I will meet with Dr. Sean Kaminsky of Pinnacle Surgical Partners on Tuesday March 10<sup>th</sup>.

I will email my surgery date and updates as soon as possible.

Sincerely,

  
Arthur C Davis, Jr.



394 Harding Place  
Suite 101  
Nashville, TN 37211  
Phone: (615) 832-9966  
FAX: (615) 832-9968

PATIENT ID: 687103  
PATIENT NAME: ARTHUR DAVIS  
DOB: REDACTED

EXAM DATE: 03/02/2015  
ACCESSION #: B685  
REFERRED BY: R. JAMES RENFRO, MD

### MRI RIGHT SHOULDER

**HISTORY:** Pain, biceps tenderness and limited range of motion. Progressive worsening since surgery February 2014. No recent trauma.

**COMPARISON STUDIES:** Radiographs right shoulder December 5, 2014.

**TECHNIQUE:** Multiplanar sequences with T1, intermediate, T2, and/or T2\*-weighted image contrast.

#### FINDINGS:

**Rotator Cuff:** Massive rotator cuff tear involving the supraspinatus and infraspinatus tendons at the greater tuberosity. The supraspinatus tendon is retracted about 4 cm and the infraspinatus tendon is retracted about 5 cm. Mild atrophy of the visualized supraspinatus muscle and moderate atrophy of the visualized infraspinatus muscle. Moderate diffuse subscapularis tendinosis with a very small irregular region of intrasubstance tearing of the distal tendon extending to the tendon footprint. No subscapularis muscle atrophy. The teres minor muscle and tendon are normal.

**Coracoacromial Arch:** Mild chronic arthritis and a minimal effusion of the acromioclavicular joint. The acromion is non-hooked and lies in neutral position. A 2 mm anterior subacromial enthesophyte. The coracoacromial ligament is not thickened.

**Glenohumeral Joint:** Mild diffuse degeneration of the glenoid labrum without definite tear. Mild biceps tenosynovitis. Mild superficial fraying of the long biceps tendon at the bicipital groove.

**Osseous/Bone Marrow:** No fracture. Evidence of previous surgical drilling in the anterodistal greater tuberosity.

**General:** Small effusions of the glenohumeral joint and subacromial-subdeltoid bursa. No soft tissue masses.

#### IMPRESSION:

1. Massive rotator cuff tear involving the supraspinatus and infraspinatus tendons at the greater tuberosity. The supraspinatus tendon is retracted about 4 cm and the infraspinatus tendon is retracted about 5 cm. Associated mild supraspinatus muscle atrophy and moderate infraspinatus muscle atrophy.
2. Moderate diffuse subscapularis tendinosis with low grade interstitial tearing of distal tendon.
3. Mild chronic arthritis of the acromioclavicular joint.
4. Mild anterior subacromial enthesopathy.
5. Mild biceps tenosynovitis and mild diffuse superficial fraying of the long biceps tendon.
6. Small effusions of the glenohumeral joint and the subacromial-subdeltoid bursa.
7. Postoperative changes in the greater tuberosity.

Subspecialty Interpretation provided by:

02/07/2015 05:54

#6120 P.001/009

STAPLES

**copy&print**

Complimentary  
Self-Serve Fax Cover Sheet

To: Aetna-Candice Hay  
Fax #: 855-733-1262  
Date: 2/7/14  
Number of Pages (Including Cover): 9

From: Arthur Davis  
Phone #: **REDACTED**  
Reply Fax #: \_\_\_\_\_  
Urgent ☐ Confidential ☐ Confirm Receipt ☐

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Claimant Name: <b>Arthur C. Davis Jr.</b>	Claimant Employer: <b>Dell Inc.</b>	Claim number: 9452367
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## Please answer the following questions as applicable:

For what time period are you appealing for benefits?	From: <b>1/12/2015</b>	To: <b>Present</b>
Have you returned to work? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
If not, do you have a projected return to work date?		
What is your job title? <b>Account Manager</b>		
Please list the requirements of your job? <b>Responsible For general account Management including calling 70-90 accounts, providing customer service and sales support. Selling all Dell products and services.</b>		
Please explain the condition(s) that are preventing you from returning to work. <b>I can no longer sit for extended periods. I have difficulty concentrating and staying focused because of Back Pain and Numbness and tingling in my feet. The pain pills make me drowsy.</b>		
What specific aspects of your job are you unable to perform and why? <b>My entire job involves complex solutions and selling. The pain in my feet and back prevents clear thinking and focus. My shoulder arm and right hand have been problematic. I have difficulty typing. The medication side effects cause daily issues.</b>		
Who are your treating providers and when did you last see each provider? If you are still receiving treatment, when is your next appointment(s)?		
Provider Name:	Date last seen:	Date next appointment:
<b>Dr. Paul Buechel KCANeurology</b>	<b>1/30/2015</b>	<b>2/24/2015</b>
<b>Dr. Tad Yane-Yoma Grassland Fam</b>	<b>1/14/2015</b>	
Are there additional records available which you intend to submit for appeal review? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
If yes, please submit all available information along with this completed appeal form.		

**Arthur C. Davis Jr.**  
Claimant signature

**2/6/15**  
Date

Signature of authorized representative

Date



Claim Number: 9452367

Employee Name  
DAVIS, ARTHUR

**9. Misrepresentation**

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

WKAB  
GR-67940-26 (8-13)

Page 3 of 3



**Davis, Arthur C. REDACTED**

1 of 3

Office/Outpatient Visit

Visit Date: Tue, Jan 20, 2015 08:23 am

Provider: Paul Buechel, MD (Assistant: Laura Kurowski)

Location: KCA Medical Group PLLC

Electronically signed by Paul Buechel, MD on 01/20/2015 09:21:10 AM

Printed on 01/23/2015 at 4:43 pm.

**SUBJECTIVE:****CC:**

Mr. Davis is a 51 year old Black or African American male. This is a follow-up visit.

**HPI:**

Low back pain noted. These are worsening; cannot sit for more than 10-15 minutes, at computer. Cannot sleep well at all; Doxepin from PCP helps sleep, but then cannot wake up. Nothing relieves the symptoms. Symptoms are worse with exertion and movement in general. He estimates that the frequency of this symptom is daily. The typical duration of an episode is variable. NSAID, Cymbalta, Ultram/TYL continue; stopped Gralise 1-2 mos ago. He is very frustrated; got a 1-12-15 letter from Aetna also [see doc scan], terminating his disability, etc. PT not helping much, but is attending,

Numbness is also noted. Seems worse, in both feet, now about the same.

Lumbar radiculopathy is also noted. MRI disc'd.

Causalgia of lower limb is also noted. Burning feet limit sleep, &amp; is also worsening, bilaterally.

**ROS:**CONSTITUTIONAL: Positive for **fatigue, night sweats and unintentional weight gain**. Negative for chills, fever or unintentional weight loss.EYES: Positive for **use of glasses or contacts**. Negative for blurred vision, eye pain or photophobia.

E/N/T: Negative for ear pain, diminished hearing, tinnitus, use of dentures, hoarseness and tooth pain.

CARDIOVASCULAR: Negative for dizziness, palpitations, pedal edema and tachycardia.

RESPIRATORY: Positive for **frequent wheezing**. Negative for recent cough or dyspnea.GASTROINTESTINAL: Positive for **constipation**. Negative for abdominal pain, acid reflux symptoms, dysphagia, diarrhea, heartburn, nausea, vomiting or odynophagia.

GENITOURINARY: Negative for dysuria, lesions on external genitalia, hematuria, high risk sexual behavior, history of recurrent UTIs, nocturia, polyuria and urinary incontinence.

MUSCULOSKELETAL: Positive for **arthralgias, back pain, joint stiffness and limb pain**. Negative for myalgias.

INTEGUMENTARY: Negative for rash.

NEUROLOGICAL: Positive for **confusion, dizziness, generalized pain, headaches, memory loss, paresthesias and weakness**. Negative for ataxia, fainting, nausea/vomiting, seizures, speech disorder, tremor or vertigo.

HEMATOLOGIC/LYMPHATIC: Negative for easy bruising, excessive bleeding and history of blood transfusion.

ENDOCRINE: Positive for **temperature intolerances, polydipsia and excessive sweating**. Negative for hair loss.ALLERGIC/IMMUNOLOGIC: Positive for **seasonal allergies and urticaria**. Negative for risk factors for HIV.PSYCHIATRIC: Positive for **anxiety**.**PMH/FMH/SH:****Past Medical History:**

Asthma, Automobile accident with injuries,

Chronic back pain,

Depression

Hypertension

**Surgical History:**

rotator cuff both shoulders 2014

**Social History:**

Tobacco: He has never smoked.

CPT is a registered trademark of the American Medical Association

**Davis, Arthur C.** [REDACTED]

2 of 3

Office/Outpatient Visit

Visit Date: Tue, Jan 20, 2015 08:23 am

Provider: Paul Buechel, MD (Assistant: Laura Kurowski)

Location: KCA Medical Group PLLC

Electronically signed by Paul Buechel, MD on 01/20/2015 09:21:10 AM

Printed on 01/23/2015 at 4:43 pm.

Smoking Status: Nonsmoker

**Tobacco/Alcohol/Supplements:**

Tobacco: He has never smoked.

**Allergies:**

Last Reviewed on 1/20/2015 08:28 AM by Buechel, Paul

No Known Drug Allergies.

**Current Medications:** Ultram PRN , XS TYL PRN .

Last Reviewed on 9/15/2014 02:06 PM by Campbell, Gretchen H.

Lisinopril/Hydrochlorothiazide 20mg/25mg Tablet Take 1 tablet(s) by mouth daily

Amlodipine 10mg Tablet Take 1 tablet(s) by mouth daily

Bystolic 10mg Tablet Take 1 tablet(s) by mouth daily

Celebrex 200mg Capsules Take 1 capsule(s) by mouth daily

Citalopram Hydrobromide 20mg Tablet 1 po q day

Cymbalta 20mg Capsules, Delayed Release Take 2 capsule(s) by mouth bid

Omeprazole 20mg Capsules, Extended Release Take 1 capsule(s) by mouth daily

Doxepin HCl 25mg Capsules Take 1 -2capsule(s) by mouth qhs

**OBJECTIVE:****Vitals:**

Current: 1/20/2015 8:31:15 AM

Ht: 6 ft, 0 in; Wt: 255 lbs; BMI: 34.6

BP: 128/90 mm Hg (left arm, sitting); P: 72 bpm (left radial, sitting); R: 14 bpm

**Exams:**

GENERAL: well developed, well nourished, in no apparent distress head normocephalic atraumatic

MUSCULOSKELETAL: digits/nails: no clubbing, cyanosis, or evidence of ischemia or infection; normal gait;

SKIN: no ulcerations, lesions, rashes or induration; skin is dry

**NEUROLOGIC:**

Mental Status: Alert and oriented x 3; Speech is fluent

Motor exam: grossly symmetrical;

Tone is normal Tremors negative Reflexes: 2/4 DTR's elicited in biceps, triceps, brachioradialis, patellar, and ankle jerks

Sensation: has reduced R L4 &amp; S1 dermatomes to sharp, still, as on prior exams.;

Coordination: Finger-to-nose intact.. Gait: Normal. see musculoskeletal exam above.

PSYCHIATRIC: alert and oriented x 3; appropriate affect and demeanor; Lumbar: exam with negative SLR's bilaterally; very tender over L4-S1 in midline, to percussion. No spasms /scoliosis.

**ASSESSMENT:**

724.2 Low back pain

DDx:

355.71 Causalgia of lower limb

DDx:

722.10 Lumbar radiculopathy

DDx:

782.0 Numbness

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**Davis, Arthur C.** [REDACTED]

3 of 3

Office/Outpatient Visit

Visit Date: Tue, Jan 20, 2015 08:23 am

Provider: Paul Buechel, MD (Assistant: Laura Kurowski)

Location: KCA Medical Group PLLC

Electronically signed by Paul Buechel, MD on 01/20/2015 09:21:10 AM

Printed on 01/23/2015 at 4:43 pm.

DDx:

**PLAN:**

Low back pain worse; he certainly cannot work, at 10-hr required sitting position at terminal, now; will resume Gralise, titrate prn; will get up to 1800 q PM by 15 days; disc'd side effects, etc.; made him groggy prior, but agrees to re-try. Also, see NS for surgical opinion. Pain clinic option disc'd too; saw 1 clinic, once, only, in past. I gave him 5 sample Gralise packets. Prior ESI x 1 no help; may need to try more.

REFERRALS: Referral initiated to physical therapy ( Results Physiotherapy ) and a neurosurgeon ( Dr. Dr.Hubbard ).

Orders:

RFPT Physical Therapist Referral (Send-Out)

RFNSUR Neurosurgeon Referral (Send-Out)

Causalgia of lower limb gralise should help; stay on other pain meds, incl. Cymbalta, Celebrex, PRN ULTRAM, TYL,

Lumbar radiculopathy NS eval.

Numbness still present on exam, as above.

Orders: Again, I feel he is fully unable to perform the duties of his job, at present, ie., that he remain on disability, therefore. F/U 3 weeks. All questions answered, in a 35 + minute visit.

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Claim Number: 9452367



## Authorization For Aetna To Request Protected Health Information Necessary To Process A Disability Claim

Please Read The Following Carefully Before Completing Your Authorization. You May Refuse To Sign This Authorization. (See Section 6.)

### 1. Member Information (Information About Person For Whom This Authorization Is Requested.)

Last Name <b>DAVIS</b>	First Name <b>ARTHUR</b>	Middle Initial <b>C</b>
Claim Number <b>9452367</b>	Year of Birth <b>REDACTED</b>	Daytime Telephone Number (include area code) <b>REDACTED</b>
Street Address <b>REDACTED</b>	City, State and ZIP <b>Spring Hill TN 37174</b>	

2. This form requests a Member's unconditioned authorization for Aetna to ask another person or organization to disclose Member's Protected Health Information ("PHI") to Aetna for the purpose of processing my disability claim.

### 3. The specific PHI we are asking you to authorize Aetna to request is (This section completed by Aetna.)

Any and all medical information including but not limited to information which relates to psychiatric or mental health, drug, substance abuse, and/or HIV infection, including AIDS and related illnesses, concerning health care, advice and treatment and prescription history records (including but not limited to, medical records, histories, physical or diagnostic examinations reports and treatment notes).

### 4. If you prefer to authorize the request of only selected categories of information, please indicate below which types of information may be disclosed. (This section completed by Member)

<input checked="" type="checkbox"/> Health (This includes medical, dental, pharmacy, vision, and flexible spending account information)
<input checked="" type="checkbox"/> Behavioral Health (e.g., mental health, drug and alcohol abuse treatment)
<input checked="" type="checkbox"/> Disability <input type="checkbox"/> Life Insurance <input type="checkbox"/> Long Term Care <input type="checkbox"/> Workers' Compensation
<input type="checkbox"/> Other: (please specify) _____

### 5. By signing this form, you will authorize Aetna to request PHI described above from the following persons or organizations (or classes of persons or organizations.)

Service Providers, including but not limited, to physicians, therapists, medical practitioners, health care professionals, workers' compensation professionals, diagnostic facilities, hospitals, clinics and pharmacy related service organizations (including individuals or facilities which provide rehabilitation services or treatment).

### 6. Expiration of this Authorization

This authorization is valid throughout the processing and any term of your disability claim unless you indicate a shorter period below.

mm/dd/yyyy

through

mm/dd/yyyy

Please review and complete important information on the reverse of this form.

WKAB  
GR-67940-26 (8-13) D

Page 1 of 3  
R-POD



Claim Number: 9452367

Employee Name ARTHUR DAVIS
-------------------------------

**7. Important: Your signature below means that you understand and agree to the following:**

- You authorize Aetna to request from the persons or organizations named above, the PHI described above, for the purposes stated above.
- The information to be disclosed may be protected by law. Information disclosed under this authorization may be re-disclosed and no longer protected by federal privacy regulations.
- Failure to complete this form may prevent Aetna from receiving information necessary for the processing of your disability claim, which may result in a disability claim denial. Failure to complete this form will not however impact your receipt of medical services from providers.
- You may revoke this Authorization at any time by notifying Aetna in writing, but please note that actions Aetna has taken before we received your revocation will still be valid under this authorization.
- You may receive a copy of this form if you request it in writing from the address listed below.

**8. Signature of Member or Legal Representative**

Signature of Member or Legal Representative <i>Arthur Cyril Davis Jr.</i>	Date 2/6/2015
Print Name Arthur Cyril Davis Jr.	

If not the Member, describe your relationship to the Member:

- ☐ Caregiver  
☐ Legal Representative  
☐ Other: \_\_\_\_\_

If Member's legal representative is signing this Authorization, you must furnish a copy of the health care power of attorney, or other relevant document designating you as the representative.

**NOTICE TO RECIPIENT(S) OF INFORMATION (Section 2. above):**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

Return this completed form to: **Aetna Life Insurance Company**  
 PO Box 14560  
 Lexington, KY 40512-4560

Telephone Number: 800-354-1779  
 Fax Number: 1-866-667-1987

WKAB  
 GR-67940-26 (8-13) D

Page 2 of 3





## Disability Appeal Request Form

We ask that you submit a request for appeal in writing. You may complete this form to assist us in review of your disability claim. You may also attach additional pages if you need more room to answer the questions below.

*Note: Completion of this form is voluntary. You may use this form to submit your appeal. If you have already submitted your appeal you may use this form to supplement your appeal, along with any other information you would like us to review with your appeal.*

Under ERISA guidelines, if you disagree with your claim determination, in whole or in part, you may file a request to appeal this decision within 180 days of receipt of this notice. The review of appeal will consist of a review of your claim based on information already existing in your file along with any additional information, records, documents, comments or other relevant material you submit in support of your appeal.

Mail or fax this completed form along with a signed copy of the enclosed Authorization for Aetna to Request Protected Health Information Necessary to Process a Disability Claim and any additional documentation to:

**Aetna Disability Appeals**  
PO Box 14578  
Lexington, KY 40512-4578  
Phone: 1-800-688-6820  
Fax: 1-855-733-1262

Claimant Name: <b>Arthur Cyril Davis Jr</b>	Claimant Employer: <b>Dell INC</b>	Claim Number: 9452367
Current Mailing Address: <b>REDACTED</b>	Can we contact you via email? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
<b>Spring Hill, TN 37174</b>	Claimant Email Address: <b>REDACTED</b>	
Home Phone: <b>Same</b>	Cell Phone: <b>REDACTED</b>	
Preferred Method of Contact: <input checked="" type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Email		
May we leave you a detailed voicemail message? (Please note that the message may include claim and/or medical information) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		

**If someone other than you is filing this appeal, please provide the following:**

Name of person assisting:	Daytime phone number:
Relationship to member:	Evening phone number:

**Please answer the following questions as applicable:**

**(Note: any additional information supplied will be utilized in support of your appeal review):**

Please state the reason why you are appealing the claim denial.

**I find myself in an unusual situation. I have worked since I was 13 yrs old but my body is failing me. My feet burn all day, my back is constantly in pain and the numerous medications have terrible side effects. I can no longer work and I need to support myself.**



Arthur Cyril Davis Jr.

**REDACTED**

Spring Hill, TN 37174

January 21, 2015

## **Aetna Long Term Disability Appeal**

Ref: Claim No. 9452367

Employee ID 00734260

Dell Inc.

Dear Ms. Lee;

On September 27, 2013 I was struck from behind by another driver. The following Monday I began to experience tingling in both my legs and I contacted an Orthopedic Back surgeon at Premier Orthopedic. From the first doctor visit until today I have been fighting to return to my previous healthy condition. I have seen numerous doctors and actually started the entire process over in October of 2014. My primary care doctor suggested I meet with Dr. Paul Buechel a neurologist in Franklin TN and we finally started to make some progress. Dr Buechel requested another MRI which showed Bone fragments, chips floating in my back.

I was attending Physical Therapy with Results Physiotherapy in Spring Hill, TN and they had pinpointed an area with spurs causing extreme pain.

I experience pain in my back 24 hours a day. I experience burning in the soles of my feet 24 hours a day. I have been trying for two months to get a full nights sleep. I was first prescribed Pamelor 25MGs, that did not work. Next it was Tramadol 100 MGs, that did not work, next it was Metaxalone 800Mgs. That did not work. Now I am taking Doxepin 25 Mgs and it does seem to work with 900 Mgs of Gralise. The problem is I am drowsy all day with these medications and it is extremely difficult to function. If I don't take the pills the foot burning gets worse and worse until it becomes unbearable.

I don't have hobbies or socialize. I go to church on Sunday mornings and I return home. I can't focus to enable reading. The constant battle with depression has reduced my phone calls to only necessary calls. I take 80 Mgs of Cymbalata and 20 Mgs of Citalopram daily for depression and back pain. I am definitely not enjoying my current situation.

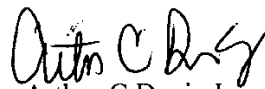
I am also experiencing issues with my right shoulder. Xrays are not conclusive and my doctor, James Renfo at Premier Orthopedics has given me two injections and I spent three sessions with Physical Therapy. There is extreme pain when I hold my arm at

0129150001

certain angles, muscle, finger and hand fatigue and I have weakness in that arm. My last injection was yesterday and I may need additional surgery.

I have worked since I was 13 years old. I was very accustomed to 60 hour work weeks and I loved it. My off hours were spent coaching sports and going to the movies or dining out. My life has changed dramatically. Dr Buechel is writing a response to your termination later and it will be sent shortly. You have copies of my medical records from Dr Buechel and he is referring me to a back surgeon to see if the Bone Spurs can be removed. He is also recommending a Pain Specialist that he feels will be more cognizant of my case. I am doing everything possible to return to work, I am going to restart Physical Therapy again and spend \$400 out of pocket for the treatments. In addition the specialist office visits average \$60-120 per visit but I am willing to pay to find a solution.

Thank you,

  
Arthur C Davis Jr

0129150001



## Fax Cover Sheet

Date 1/22/15Number of pages 3 (including cover page)

To:

Name Actualife NS Co

From:

Name Arthur Dawing JrCompany Dell IN: AppealsCompany Telephone Telephone **REDACTED**Fax 855-733-1262Comments 

Fax - Local Send

fedex.com 1.800.GoFedEx 1.800.463 339

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Fax - Domestic Send



Fax - International Send

22705

DCN: 150122119282 PAGE: 001 SEQUENCE: SAF0123201500011001 TimeStamp: 10:01:26 pm EST

Arthur Cyril Davis Jr.

**REDACTED**

Spring Hill, TN 37174

January 21, 2015

**Aetna Long Term Disability Appeal**

Ref: Claim No. 945236  
Employee ID 0073426  
Dell Inc.

Dear Ms. Lee;

On September 27, 2013 I was struck from behind by another driver. The following Monday I began to experience tingling in both my legs and I contacted an Orthopedic Back surgeon at Premier Orthopedic. From the first doctor visit until today I have been fighting to return to my previous healthy condition. I have seen numerous doctors and actually started the entire process over in October of 2014. My primary care doctor suggested I meet with Dr. Paul Buechel a neurologist in Franklin TN and we finally started to make some progress. Dr Buechel requested another MRI which showed Bone fragments, chips floating in my back.

I was attending Physical Therapy with Results Physiotherapy in Spring Hill, TN and they had pinpointed an area with spurs causing extreme pain.

I experience pain in my back 24 hours a day. I experience burning in the soles of my feet 24 hours a day. I have been trying for two months to get a full nights sleep. I was first prescribed Ibuprofen 25MGs, that did not work. Next it was Tramadol 100MGs, that did not work. Next it was Metaxalone 800Mgs. That did not work. Now I am taking Doxepin 25 Mgs and it does seem to work with 900 Mgs of Gralise. The problem is I am drowsy all day with these medications and it is extremely difficult to function. If I don't take the pills the foot burning gets worse and worse until it becomes unbearable.

I don't have hobbies or socialize. I go to church on Sunday mornings and I return home. I can't focus to enable reading. The constant battle with depression has reduced my phone calls to only necessary calls. I take 80 Mgs of Cymbalata and 20 Mgs of Citalopram daily for depression and back pain. I am definitely not enjoying my current situation.

I am also experiencing issues with my right shoulder. Xrays are not conclusive and my doctor, James Renfro at Premier Orthopedics has given me two injections and I spent three sessions with Physical Therapy. There is extreme pain when I hold my arm at

certain angles, muscle finger and hand fatigue and I have weakness in that arm. My last injection was yesterday and I may need additional surgery.

I have worked since I was 13 years old. I was very accustomed to 60 hour work weeks and I loved it. My off hours were spent coaching sports and going to the movies or dining out. My life has changed dramatically. Dr Buechel is writing a response to your termination later and it will be sent shortly. You have copies of my medical records from Dr Buechel and he is referring me to a back surgeon to see if the Bone Spurs can be removed. He is also recommending a Pain Specialist that he feels will be more cognizant of my case. I am doing everything possible to return to work, I am going to restart Physical Therapy again and spend \$400 out of pocket for the treatments. In addition the specialist office visits average \$60-120 per visit but I am willing to pay to find a solution.

Thank you,

  
Arthur C Davis Jr





## Fax Message

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**To:** AETNA BES

**Fax:** 1-866-667-1987

**From:** Garcia, Frances E

**Date:** 1/14/2015 12:46 PM

**Pages:** 1 of 5 (including this page)

**Subject:** SSDI Reconsideration Appeal Denial Letter Claim# 9452367 LTD Member :  
DAVIS,ARTHUR

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**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

SSDI Reconsideration Appeal Denial Letter Claim# 9452367 LTD Member : DAVIS,ARTHUR

Fran Garcia  
Allsup Onsite Administrative Assistant  
Aetna Tampa

**Social Security  
Notice of Reconsideration**928  
359/DRJ

R

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From: Social Security Administration

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ARTHUR C DAVIS JR

**REDACTED**

MURFREESBORO TN 37128

DATE: 01/09/15

CLAIM NUMBER: **REDACTED**

## CLAIM FOR

- ☒ Disability Insurance Benefits
- ☐ Disabled Widow, Widower Benefits
- ☐ Childhood Disability Benefits
- ☐ Medicare Coverage Only

Upon receipt of your request for reconsideration we had your claim independently reviewed by a physician and disability examiner in the State agency which works with us in making disability determinations. The evidence in your case has been thoroughly evaluated; this includes the medical evidence and the additional information received since the original decision. We find that the previous determination denying your claim was proper under the law. Attached to this notice is an explanation of the decision we made on your claim and how we arrived at it. The reverse of this notice identifies the legal requirements for your type of claim.

The determination on your claim was made by an agency of the State. It was not made by your own doctor or by other people or agencies writing reports about you. However, any evidence they gave us was used in making this determination. Doctors and other people in the State agency who are trained in disability evaluation reviewed the evidence and made the determination based on Social Security law and regulations.

If you believe that the reconsideration determination is not correct, you may request a hearing before an administrative law judge of the Office of Disability Adjudication and Review. If you want a hearing you must request it not later than 60 days from the date you receive this notice. You may make your request through any Social Security office or on the Internet at <http://www.socialsecurity.gov/disability/appeal>. As part of the appeal process, you also need to tell us about your current medical condition. We provide a form for doing that, the Disability Report - Appeal. You may contact one of our offices or call 1-800-772-1213 to request this form. Or, you may complete the report online after you complete the online Request for Hearing by Administrative Law Judge. Read the enclosed leaflet for full explanation of your right to appeal.

You have the right to file a new application at any time, but filing a new application is not the same as appealing this decision. You might lose benefits if you file a new application instead of filing an appeal. Therefore, if you think this decision is wrong, you should ask for an appeal within 60 days.

This decision refers only to your claim for benefits under the Social Security Disability Insurance Program. If you applied for other benefits, you will receive a separate notice when a decision is made on that claim(s).

If you have questions about your claim, you should get in touch with any Social

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Form SSA-L928-U2 (2-90)

Security office. Most questions can be handled by telephone or mail. If you visit an office, however, please take this letter with you.

Summarized below are legal requirements for the various types of disability claims:

#### DISABILITY INSURANCE CLAIM

To be considered disabled, a person must be unable to do any substantial gainful work due to a medical condition which has lasted or is expected to last for at least 12 months in a row. The condition must be severe enough to keep a person from working not only in his or her usual job, but in any other substantial gainful work. We look at the person's age, education, training and work experience when we decide whether he or she can work.

#### DISABLED WIDOW (WIDOWER) CLAIM

A widow, widower, or surviving divorced wife (age 50-60) must meet the disability requirement of the law within a specified 7-year period. A person may be considered disabled only if he or she has a physical or mental impairment that is so severe as to ordinarily prevent a person from working. The disability must have lasted or be expected to last a continuous period of at least 12 months.

#### CHILDHOOD DISABILITY BENEFITS

Childhood disability benefits may be paid to a person age 18 or older if the person has a disability which began before age 22 or within 84 months of the end of an earlier period of childhood disability. The condition, whether physical or mental, must be severe enough to keep the person from doing any substantial gainful work. We look at the person's age, education and previous training when we decide whether he or she can work. In addition, the condition must have lasted or be expected to last for at least 12 months in a row.

Enclosure:  
SSA Pub. No. 70-10281,

565

cc: Lindsey Lehman  
300 Allsup Place  
Belleville IL 62223

X47042/359/KDW

## SOCIAL SECURITY ADMINISTRATION

## EXPLANATION OF DETERMINATION

Name of Claimant	N/E's Name (If CDB or DWB)	SSN	Type of Claim
ARTHUR C DAVIS JR		REDACTED	RCDIB

The following reports were used to decide this claim in addition to those listed on the previous notice:

PREMIER RADIOLOGY 11/06/13 11/06/14  
Dr Jason R Knox DPM 06/09/14  
DR WILLIAM FLEET MD 03/27/12 02/24/14  
TOTTY CHIROPRACTIC 09/08/14 09/10/14  
DR BRENNIA GREEN DO 10/22/13 06/19/14  
HERITAGE MEDICAL ASSOCIATES 02/19/13 10/20/14

We requested but did not receive any other reports. However, the above reports contained enough information to evaluate this claim.

We have looked again at all the information regarding your condition.

You said you are unable to work because of a back injury, shoulder pain, pain in both knees, foot burning, asthma, high blood pressure, depression, anxiety, concentration problems, and memory problems.

Although you do have back, shoulder, knee, and foot pain, the evidence shows that you are able to stand, move about and use your arms, hands and legs in a satisfactory manner.

Although you have stated that you are short of breath, medical records show your breathing capacity to be adequate for many daily activities.

The evidence shows that your blood pressure, though higher than normal at times, has not seriously damaged your heart, kidney, or other vital organs.

Although you experience depression, anxiety, concentration problems, and memory problems, your records show that you are able to communicate with others, act in your own interest and perform most ordinary activities.

We do not have sufficient vocational information to determine whether you can perform any of your past relevant work. However, based on the evidence in file, we have determined that you can adjust to other work.

We have determined that your condition is not severe enough to keep you from working. We considered the medical and other information, your age, education, training, and work experience in determining how your condition affects your ability to work.

If your condition gets worse and keeps you from working, write, call or visit any Social Security office about filing another application.

The determination on this claim was made by an agency of the State. It was not made by the doctors or other people or agencies who submitted reports. Any evidence they gave us was used in making the determination. Doctors and other people in the State agency who are trained in disability evaluation reviewed the evidence and made the determination based on Social Security law and regulations.

Claim Number: 9452367



## Authorization For Aetna To Request Protected Health Information Necessary To Process A Disability Claim

Please Read The Following Carefully Before Completing Your Authorization. You May Refuse To Sign This Authorization. (See Section 6.)

### 1. Member Information (Information About Person For Whom This Authorization Is Requested.)

Last Name <b>DAVIS</b>	First Name <b>ARTHUR</b>	Middle Initial <b>C</b>
Claim Number <b>9452367</b>	Year of Birth <b>REDACTED</b>	Current Telephone Number (include area code) <b>REDACTED</b>
Street Address <b>REDACTED</b>	City, State and ZIP <b>Murfreesboro, TN 37128</b>	

2. This form requests a Member's unconditioned authorization for Aetna to ask another person or organization to disclose Member's Protected Health Information ("PHI") to Aetna for the purpose of processing my disability claim.

### 3. The specific PHI we are asking you to authorize Aetna to request is (This section completed by Aetna.)

Any and all medical information including but not limited to information which relates to psychiatric or mental health, drug, substance abuse, and/or HIV infection, including AIDS and related illnesses, concerning health care, advice and treatment and prescription history records (including but not limited to, medical records, histories, physical or diagnostic examinations reports and treatment notes).

### 4. If you prefer to authorize the request of only selected categories of information, please indicate below which types of information may be disclosed. (This section completed by Member)

<input type="checkbox"/> Health (This includes medical, dental, pharmacy, vision, and flexible spending account information)
<input type="checkbox"/> Behavioral Health (e.g., mental health, drug and alcohol abuse treatment)
<input type="checkbox"/> Disability <input type="checkbox"/> Life Insurance <input type="checkbox"/> Long Term Care <input type="checkbox"/> Workers' Compensation
<input type="checkbox"/> Other: (please specify) _____

### 5. By signing this form, you will authorize Aetna to request PHI described above from the following persons or organizations (or classes of persons or organizations.)

Service Providers, including but not limited, to physicians, therapists, medical practitioners, health care professionals, workers' compensation professionals, diagnostic facilities, hospitals, clinics and pharmacy related service organizations (including individuals or facilities which provide rehabilitation services or treatment).

### 6. Expiration of this Authorization

This authorization is valid throughout the processing and any term of your disability claim unless you indicate a shorter period below.

mm/dd/yyyy	through	mm/dd/yyyy
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Please review and complete important information on the reverse of this form.

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Page 1 of 3  
R-P00



0220140004

0112150030

IDCN: 140220058745 PAGE: 019 SEQUENCE: 0220140004

Aetna - 01/15/11 11:11 AM

Aetna - 01/15/11 11:11 AM

Employee Name	ARTHUR DAVIS
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- You authorize Aetna to request from the persons or organizations named above, the PHI described above, for the purposes stated above.
- The information to be disclosed may be protected by law. Information disclosed under this authorization may be re-disclosed and no longer protected by federal privacy regulations.
- Failure to complete this form may prevent Aetna from receiving information necessary for the processing of your disability claim, which may result in a disability claim denial. Failure to complete this form will not however impact your receipt of medical services from providers.
- You may revoke this Authorization at any time by notifying Aetna in writing, but please note that actions Aetna has taken before we received your revocation will still be valid under this authorization.
- You may receive a copy of this form if you request it in writing from the address listed below.

Signature of Member or Legal Representative <i>Arthur C Davis</i>	Date <i>02/11/2014</i>
Print Name <i>Arthur C Davis, Jr.</i>	

☐ Caregiver  
☐ Legal Representative  
☐ Other: \_\_\_\_\_

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. *Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.*

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DCN: 140220058745 PAGE: 021 SEQUENCE: 0220140004

Claim Number: 9452367

Employee Name

DAVIS, ARTHUR

#### 9. Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

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Page 3 of 3



0220140004

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DOI: 140220058745 PAGE: 025 SEQUENCE: 0220140004



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needs updated records

12-29  
APPT

Franklin TN - 37068

Kpt

DOB: REDACTED

Dear ARTHUR C DAVIS:

**The Dell Inc group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna).**

**We are writing in regards to your ongoing claim for Long Term Disability (LTD) benefits. Please review this entire letter as it contains important information regarding your eligibility for ongoing benefits.**

We have made several attempts to reach your physician(s) Dr. Steven Nyquist and Dr. Tadayuki Yoneyama on 11/06/2014 and 11/21/2014 to obtain updated information on your claim. To date, we have not received the requested information.

**In regard to disability, your policy indicates:**

### A Period of Disability

A period of disability starts on the first day you are disabled as a direct result of a significant change in your physical or mental condition occurring while you are insured under this Plan. You must be under the regular care of a physician. (You will not be deemed to be under the regular care of a physician more than 31 days before the date he or she has seen and treated you in person for the disease or injury that caused the disability.)

**Your period of disability ends on the first to occur of:**

- The date Aetna finds you are no longer disabled or the date you fail to furnish proof that you are disabled.
- The date you cease to be under the regular care of a physician.

**If you continue to be disabled, your disability benefit plan requires you to be under the care of a physician and to submit continuing proof of your disability. Updated medical documentation to certify your disability will be needed from your disabling Physicians every 3 months or after every follow up appointment.**

This information is necessary for us to determine whether you continue to meet the definition of disability described in your LTD plan, as it will provide us information regarding how your medical condition imposes limitations upon your ability to perform your work duties.

**Provide us with current medical documentation which:**

- Established that you are disabled from your own occupation;
- Includes medical documentation, such as chart notes and diagnostic test results, to support your diagnosis and claim for disability; and

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- Provides specific functional abilities, including any and all restrictions and limitations.

We encourage you to contact your providers and expedite this request, as it is ultimately your responsibility to provide proof of disability. Please forward this information to our office no later than 12/24/2014 or your LTD benefits may be jeopardized. If we do not receive the current office notes from all disabling physicians by 12/24/2014, your claim will be reviewed based on what is currently in your file and your claim may be closed.

**If you have any questions, please call 800-354-1779.**

**Sincerely,**

**SHAWNDR A LEE**  
**LTD BENEFIT MANAGER**  
**Aetna Life Insurance Company**

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**aetna**<sup>SM</sup>

## Fax Message

**To:** Dr. Steven Nyquist**Fax:** 615-771-1109**From:** Lee, Shawndra E**Date:** 11/6/2014 3:11 PM**Pages:** 1 of 4 (including this page)**Subject:** Re: Arthur Davis REDACTED**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

0112150030

**Disability Services**  
P.O. Box 14560  
Lexington, KY 40512

**AUTHOR: DAVID  
REDACTED**

11/11/2019 11:11:11 AM

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AETNA

SHAWNDR LEE

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PO BOX 14560

LEXINGTON, KY 40512-4560



## ATTENTION

Confidential Information enclosed.  
To be viewed by authorized persons only.

If you have questions regarding any information you have requested,  
please call the phone number on the enclosed invoice.

Health information is reproduced by HealthPort, a health information management outsourcing service. Your healthcare provider contracts with HealthPort to process authorized requests for copies of health records.

Reproductions are made from the medical facility's original records. The confidentiality of these records is protected by federal and state laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

If you requested items that are not maintained in the medical record, your request for those items was forwarded to the appropriate department and will be sent under separate cover. Likewise, information that you asked to have delivered to another address is sent separately.

This package may or may not contain medical records, depending on what was requested and how it was processed.

You may not make any disclosure or use of these records without the permission of the individual who is the subject of the records.

0112150030



## Fax Message

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**To:** BES  
**Fax:** 866-667-1987  
**From:** Lee, Shawndra E  
**Date:** 1/8/2015 12:14 PM  
**Pages:** 1 of 5 (including this page)  
**Subject:** Re: Job Description on claim# 9452367

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**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Shawndra Lee  
LTD Disability Benefit Manager  
Aetna Inc.  
Disability and Leave Management Services  
Toll Free Number (800)354-1779, ext 6932227  
Direct : (954)693-2227  
Fax: (866)667-1987  
Email : Lees4@aetna.com

## STD\_LOA

**From:** Susan\_Parker@Dell.com  
**Sent:** Friday, January 17, 2014 10:32 AM  
**To:** STD\_LOA; US\_Leave\_Administrator@Dell.com  
**Cc:** RTW  
**Subject:** RE: Action Needed - Job Analysis Worksheet: DAVIS, A. - Claim: 8893435

Dell - Internal Use - Confidential

**From:** STD\_LOA@aetna.com [mailto:STD\_LOA@aetna.com]  
**Sent:** Friday, January 17, 2014 9:20 AM  
**To:** STD\_LOA@aetna.com; US Leave Administrator; Parker, Susan  
**Cc:** std\_loa@aetna.com; rtw@aetna.com  
**Subject:** Action Needed - Job Analysis Worksheet: DAVIS, A. - Claim: 8893435

Action Needed: ARTHUR DAVIS - Claim: 8893435

Your company provides Aetna with a generic job description. However, as part of Aetna's claim administration process, specific job duties are necessary therefore we are asking you to complete the Job Analysis worksheet below and return it to my attention as quickly as possible. Failure to do so may result in a delay or denial of this employee's claim. Also, if the employee has returned to work, please notify Aetna as soon as possible. Thank you for your assistance.

FIRST DAY ABSENT: 10/09/2013  
LAST DAY WORKED: 10/08/2013  
PROJECTED RETURN TO WORK:

### Job Analysis

(To Be completed by employee's Immediate Supervisor)

Employee: Arthur Davis Job Title: inside sales  
rep

STD Case \_\_\_\_\_ Days worked per week: 5 No. of hours per day: 8 Overtime? Yes ☒ No ☐

Brief Description of Job Duties:

Using the above guidelines, please rate each of the following activities as *Frequent, Occasional, Seldom, or*



Never:

Lifting/Carrying	Frequent	Occasional	Seldom	Never	Can Assistance be Provided?	Describe Assistance
1-10 lbs.				x		
11-20 lbs.				x		
21-50 lbs.				x		
51-100 lbs.				x		
Over 100 lbs.				x		
Pushing				x		
Pulling				x		
Reaching				x		
Overhead Work				x		
TRAVELLING _____ DOMESTIC _____ INTERNATIONAL _____ PER WEEK _____ PER MONTH _____						

Indicate number of hours per day each activity is performed:

Sitting 8 Walking Standing Kneeling Squatting Climbing Stairs Supervising Others

Occupational Requirements (check all that apply)

Senses: Far Vision Near Vision x Peripheral Vision Depth Perception Hearing x Talking x  
Repetitive Hand Use: Simple Grasp Twisting Motion Fine Manipulation Typing/Keyboarding x

Occupational Hazards (check all that apply):

Machine Operation Vibration Extreme Heat/Cold Noise x Fumes/Gasses/Chemicals Vehicle  
Operation Poor Lighting Poor Ventilation Dust others

Cognitive Abilities (Indicate hours per day each task is required):

x Follow Directions and Routines Concentrate, Memorize and Recall x Analyze Data x Problem  
Solving Plans Activities or Projects Planning and Organizing x Work Independently With Appropriate  
Judgment x Read, Write and Comprehend Numbers and Words

Other Dimensions (Indicate hours per day each task is required):

x Communicate Via Telephone x Complete Paperwork Responsibilities Express Ideas Effectively in Individual  
and Group Situations x Building Relationships x Negotiating/Influencing

Additional Comments:

Susan Parker

Name of Individual Completing Form

Division/Location

Susan Parker- inside sales manager

512-513-2701

Signature and Title

Telephone No.

Fax No.

1/8/2015 12:14 PM  
1/17/2014 11:47 AM

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Page 5 of 5  
Page 4 of 4

Please contact us if you have any questions concerning this request.

AKINKAWON TURNER  
STD / LOA Benefit Manager  
800-354-1779 extension 6932726

This e-mail may contain confidential or privileged information. If you think you have received this e-mail in error, please advise the sender by reply e-mail and then delete this e-mail immediately. Thank you. Aetna



**PO BOX 19072**  
**GREEN BAY WI 54307-9072**  
**Voice : 866-420-7455 Fax : 920-406-6537**

12/24/2014

---

To  
Company AETNA  
Fax Number 18776937258  
Voice Number 800-882-5968

From Customer Relations  
Fax 920-406-6537  
Voice 866-420-7455  
Subject **InvalidApprovalnotice**  
Order # 36177201

Notes

This fax and any files transmitted with it are confidential and may contain information which is legally privileged or otherwise exempt from disclosure. They are intended solely for the use of the individual or entity to whom this fax is addressed. If you are not one of the named recipients or otherwise have reason to believe that you have received this fax in error, please immediately notify the sender and return or shred these documents immediately. Any other use, retention, dissemination, forwarding, printing, or copying of this email is strictly prohibited

# Invalid Authorization Notice



NOTICE DATE: 12/24/2014

**AETNA**  
**PO BOX 14560**  
**LEXINGTON, KY 40512-4560**

Patient: **DAVIS, ARTHUR**  
SSN:  
Claim/File #: **9452367**  
Order #: **36177201**  
Fax #: **877-693-7258**

IMG

Records requested from: **HERITAGE MEDICAL ASSOCIATES**

**Dear Requester:**

iod incorporated has been retained by the medical facility listed above to handle release of information requests such as yours.

Unfortunately we will not be able to comply with your request due to the following:

**The Authorization to release the records is not valid in accordance with State or Federal law.**

- » Authorization is not HIPAA compliant.
- » Please complete the enclosed Patient Authorization Form and mail or fax it back to us.

If you have any questions regarding this notice, please contact Medical Records Department at 615-284-2222.

*iod incorporated Tax ID No. 65-0765287*  
222 22ND STREET SUITE 100 NASHVILLE, TN 37203  
Phone 615-284-2222 \* Fax 615-327-5461



**Medical Records Release Authorization**

Version 1.3 External

I hereby authorize Heritage Medical Associates to release or disclose to the below-named facility all of my medical records, including any specially protected records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection for the purpose of medical treatment.

**Please "Print" and complete all sections to insure your request is handled in a timely manner**  
**MAIL RECORDS TO:** \_\_\_\_\_

Special Instructions if any:  
(Specific information requested, etc.) \_\_\_\_\_

**PURPOSE OF DISCLOSURE:** \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Patient's S.S.# \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

**If you Do Not Want certain portions of your medical records released, please read this section carefully and initial the boxes for information you do not want released. Otherwise, your records will be released as specified above.**

\*I hereby authorize (Physician/facility's full name) \_\_\_\_\_ to release the information specified to the organization, agency, or individual named on this request with the exception of:

Initials \_\_\_\_\_ Initials \_\_\_\_\_ Initials \_\_\_\_\_  
\_\_\_\_\_ Substance abuse, if any \_\_\_\_\_ Psychological or psychiatric conditions, if any \_\_\_\_\_ AIDS/HIV/STD's, if any

*This Authorization will expire on the following date or upon the occurrence of the following event: \_\_\_\_\_*

\* I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by Heritage Medical Associates or its physicians, employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to Heritage Medical at the address shown below.

\* I understand that I am not required to sign this Authorization. Heritage Medical Associates will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

\* I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit Heritage Medical Associates' or its physicians', employees' or agents' ability to use or disclose my information for treatment, payment, or health care operations, or as otherwise permitted by law.

**Patient or Authorized Representative's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to the patient:** \_\_\_\_\_

Heritage Medical Associates \* 222 22<sup>nd</sup> Ave. North, Ste 100, Nashville, TN 37203-1870 \* (615) 284-2222

**For an Authorization to be valid, in accordance with State and Federal laws, it must contain all of the following points:**

<b>1.</b>	<b>Identify the Patient.</b> The Patient's name is necessary. The Patient's Date of Birth and/or Social Security Number is optional, but is useful in correctly identifying the Patient.
<b>2.</b>	<b>Be dated.</b>
<b>3.</b>	<b>I include a specific expiration date</b> or event that pertains to the purpose of the disclosure. "24 Months", "One year", "Valid for the duration of the claim", are considered specific. The request for records created after the date of signature on the authorization cannot be released. Please update your authorization to include "records created after date of signature" and have the patient sign it and submit this to us so that we may release the records requested.
<b>4.</b>	<b>Not be expired</b> by the date the request was received. It is permissible to release records beyond the expiration date as long as it was received prior to the expiration date.
<b>5.</b>	<b>Be signed</b> by the patient or the patient's personal representative. The patient's personal representative is a person who is able to authorize medical treatment for the patient or who is acting on behalf of a deceased patient. If the authorization was signed by the Patient's personal representative, then it must provide proof of Legal Guardianship or Power of Attorney and it must provide a description of the patient's personal representative's authority to act for the patient with regard to Healthcare.
<b>6.</b>	<b>Include the name of the provider</b> being asked to disclose the information. It is not OK for the Provider to be identified on the cover letter of the request; it does have to be included in the body of the Authorization form.
<b>7.</b>	<b>Provide the name and address of the Requester</b> to which the information is to be disclosed. It is OK for the Requester name and address to be provided on the cover letter of the request; it does not have to be included in the body of the Authorization form.
<b>8.</b>	<b>Provide a specific and meaningful description of the information to be disclosed.</b> Examples: "ER Report from 5/1/99", "Any and all records" etc.
<b>9.</b>	<b>Give a brief description of the purpose of the disclosure.</b> Examples: "My own personal use", "Legal", "Transferring care", "Insurance benefits" etc. The statement, "at the request of the individual/patient", is sufficient for this purpose.
<b>10.</b>	<b>Specifically cover any State and/or Federally protected information</b> if protected information is contained in the patient's chart.
<b>11.</b>	<b>Include a statement concerning the patient's right to revoke the authorization in writing.</b>
<b>12.</b>	<b>Include a statement regarding the exceptions to the right to revoke an authorization</b> and a description of how to revoke, or a reference to the Notice of Privacy Practices that includes this information.
<b>13.</b>	<b>Include a statement whether the information disclosed might be re-disclosed</b> by the recipient, and therefore, no longer protected..
<b>14.</b>	<b>If the requesting party is a health plan (i.e.: Regence, Molina, Blue Cross, Medicare, etc.) and they are requesting records for a patient who is applying for Health Insurance, then ...</b> include a statement that the Health Care Provider may not condition treatment, payment or eligibility for benefits on whether the patient signs the authorization, or if the Health Care Provider can condition treatment on obtaining authorization, a description of the consequences to the patient for refusing to sign.



PO Box 14560  
Lexington, KY 40512-4560  
SHAWNDR LEE  
LTD BENEFIT MANAGER  
Phone: 800-354-1779  
Fax: 1-866-667-1987

12/09/2014

FROM:

ARTHUR DAVIS  
**REDACTED**  
Franklin TN - 37068

Group Control No: 0476626  
Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

Dear ARTHUR C DAVIS:

The Dell Inc group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna).

We are writing in regards to your ongoing claim for Long Term Disability (LTD) benefits. Please review this entire letter as it contains important information regarding your eligibility for ongoing benefits.

On 11/24/2014, we advised you through mail that we have not been successful in obtaining updated medical information from your physician(s).

We have made several attempts to reach your physician(s) Dr. Steven Nyquist and Dr. Tadayuki Yoneyama on 11/06/2014 and 11/21/2014 to obtain updated information on your claim. To date, we have not received the requested information.

In regard to disability, your policy indicates:

**A Period of Disability**

A period of disability starts on the first day you are disabled as a direct result of a significant change in your physical or mental condition occurring while you are insured under this Plan. You must be under the regular care of a physician. (You will not be deemed to be under the regular care of a physician more than 31 days before the date he or she has seen and treated you in person for the disease or injury that caused the disability.)

Your period of disability ends on the first to occur of:

- The date Aetna finds you are no longer disabled or the date you fail to furnish proof that you are disabled.
- The date you cease to be under the regular care of a physician.

If you continue to be disabled, your disability benefit plan requires you to be under the care of a physician and to submit continuing proof of your disability. Updated medical documentation to certify your disability will be needed from your disabling Physicians every 3 months or after every follow up appointment.

This information is necessary for us to determine whether you continue to meet the definition of disability described in your LTD plan, as it will provide us information regarding how your medical condition imposes limitations upon your ability to perform your work duties.

Provide us with current medical documentation which:

DCN: 14122256756 PAGE: 001 SEQUENCE: SWF1223201400405001 TimeStamp: 11:30:02 pm EST

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Sincerely,

DCN: 141222256756 PAGE: 003 SEQUENCE: SWF1223201400405001 TimeStamp: 11:30:02 pm EST



**aetna**  
Disability Services  
P.O. Box 14560  
Lexington, KY 40512

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ARTHUR DAVIS  
REDACTED  
FRANKLIN TN 37068-1311



J01114A  
IDR  
20141210561 J83D  
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Davis, Arthur C. **REDACTED**

1 of 3

Office/Outpatient Consultation

Visit Date: Thu, Oct 16, 2014 11:21 am

Provider: Paul Buechel, MD (Assistant: Ashton Lyons, )

Location: KCA Medical Group PLLC

Electronically signed by Paul Buechel, MD on 10/16/2014 12:28:45 PM

Printed on 12/22/2014 at 10:52 am.

## SUBJECTIVE:

### CC:

Mr. Davis is a 51 year old male. He is here today for a consultation following a referral from the Primary Care Physician.

### HPI:

Mr. Davis presents with low back pain.. It began 09-27-2013. Symptoms are better with meds. Aggravating factors include exertion and movement in general. He estimates that the frequency of this symptom is daily. The typical duration of an episode is quite variable. Also he is having pains in R > L feet & ankles, of burn quality in feet, & "twisted sense" in ankles. This gets worse with physical activity, but he still tries to exercise 5 days/week, including stretching out his back, if feeling less pain, though he is always in some discomfort.

His problems started after an MVA in which he was rear-ended, 9-27-13; he had bilateral rotator cuff tears fixed, then saw Dr. Kaufman of ortho for his spine; L-MR report from 11-6 -13 was reviewed today, with "mild n.f. narrowing at R L4-5 & L L5-S1".

He was in PT 2 mos, then tried "boot camp " PT too, then in 3/14, R foot started burning, now L side too, to lesser degree, esp. both at HS.

Dr. Prasad did 5/14 EMG, & told him he couldn't help; Arthur is frustrated, as has seen many docs, without benefit. His PCP has helped, though, with Cymbalta, some.

Had ESI's from Dr. Green @ pain clinic, x 1 , with only 24 hrs' benefit. Was severely painful, too.

Also has seen Drs. Cote [FP], & Knox[podiatry].

Has sleep issues; just got back with wife, & also closing on house; trying to stay positive, he just started seeing Psych/a therapist, & Celexa was started.

Also rarely uses Oxycontin PRN sleep, only, & is on Celebrex 200/d.

No sciatica.

### ROS:

CONSTITUTIONAL: Positive for **fatigue, night sweats and unintentional weight gain**. Negative for chills, fever or unintentional weight loss.

EYES: Positive for **use of glasses or contacts**. Negative for blurred vision, eye pain or photophobia.

E/N/T: Negative for ear pain, diminished hearing, tinnitus, use of dentures, hoarseness and tooth pain.

CARDIOVASCULAR: Negative for dizziness, palpitations, pedal edema and tachycardia.

RESPIRATORY: Positive for **frequent wheezing**. Negative for recent cough or dyspnea.

GASTROINTESTINAL: Positive for **constipation**. Negative for abdominal pain, acid reflux symptoms, dysphagia, diarrhea, heartburn, nausea, vomiting or odynophagia.

GENITOURINARY: Negative for dysuria, lesions on external genitalia, hematuria, high risk sexual behavior, history of recurrent UTIs, nocturia, polyuria and urinary incontinence.

MUSCULOSKELETAL: Positive for **arthralgias, back pain, joint stiffness and limb pain**. Negative for myalgias.

INTEGUMENTARY: Negative for rash.

NEUROLOGICAL: Positive for **confusion, dizziness, generalized pain, headaches, memory loss, paresthesias and weakness**. Negative for ataxia, fainting, nausea/vomiting, seizures, speech disorder, tremor or vertigo.

HEMATOLOGIC/LYMPHATIC: Negative for easy bruising, excessive bleeding and history of blood transfusion.

ENDOCRINE: Positive for **temperature intolerances, polydipsia and excessive sweating**. Negative for hair loss.

ALLERGIC/IMMUNOLOGIC: Positive for **seasonal allergies and urticaria**. Negative for risk factors for HIV.

PSYCHIATRIC: Positive for **anxiety**.

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**Davis, Arthur C.** [REDACTED]

Office/Outpatient Consultation

Visit Date: Thu, Oct 16, 2014 11:21 am

Provider: Paul Buechel, MD (Assistant: Ashton Lyons, )

Location: KCA Medical Group PLLC

Electronically signed by Paul Buechel, MD on 10/16/2014 12:28:45 PM  
Printed on 12/22/2014 at 10:52 am.

**Current Medications:**

Last Reviewed on 9/15/2014 02:06 PM by Campbell, Gretchen H.  
None

**OBJECTIVE:**

**Vitals:**

**Current:** 10/16/2014 11:24:58 AM

Ht: 6 ft, 0 in; Wt: 245 lbs; BMI: 33.2

BP: 144/88 mm Hg (left arm, sitting); P: 82 bpm; R: 18 bpm

**Exams:**

**GENERAL:** well developed, well nourished, in no apparent distress head normocephalic atraumatic  
**EYES:** lids and conjunctiva are normal; pupils and irises are normal; fundoscopic exam shows normal optic discs  
**MUSCULOSKELETAL:** digits/nails: no clubbing, cyanosis, or evidence of ischemia or infection; normal gait;  
**SKIN:** no ulcerations, lesions, rashes or induration; skin is dry

**NEUROLOGIC:**

Mental Status:: Alert and oriented x 3; Speech is fluent cranial nerves II-XII intact;

Motor exam: 5/5 bilateral upper and lower extremities;

Tone is normal Tremors negative Reflexes: 2/4 DTR's elicited in biceps, triceps, brachioradialis, patellar, and ankle jerks

Sensation: has reduced R L4 & S1 dermatomes to sharp.;

Coordination: Finger-to-nose intact. Gait: see musculoskeletal exam above.

**PSYCHIATRIC:** alert and oriented x 3; appropriate affect and demeanor; no stocking loss, vibr/position OK, no clonus/increased leg tone. romberg OK. SLR/patrick's OK bilat. No spinal column/muscle tenderness, to percussion. No spasm palpable.

**Lab/Test Results:**

**NEURO TEST RESULTS:** Lumbar MRI: as above. Chart from previous neurology practice reviewed in detail. Chart from PCP reviewed in detail.

**ASSESSMENT:**

724.2 Low back pain

DDx:

355.71 Causalgia of lower limb

DDx:

722.10 Lumbar radiculopathy

DDx:

782.0 Numbness

DDx:

**PLAN:**

**Low back pain** seems musculoskeletal, +/- radicular; stressed need to stay active, with daily stretches, & his workouts, up to 5 d/wk, as tolerated.

**Causalgia of lower limb** for his neuropathic pains, will try Gralise, with Cymbalta. He uses very occasional Oxycontin, too.

Cautioned about side effects of medication(s) in detail. Patient/caregiver expressed understanding. Discussed titration of

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**Davis, Arthur C.** [REDACTED]

Office/Outpatient Consultation

Visit Date: Thu, Oct 16, 2014 11:21 am

Provider: Paul Buechel, MD (Assistant: Ashton Lyons, )

Location: KCA Medical Group PLLC

Electronically signed by Paul Buechel, MD on 10/16/2014 12:28:45 PM

Printed on 12/22/2014 at 10:52 am.

medication. Written instructions provided.

Prescriptions:

Gralise (Gabapentin) 600mg Tablet take 1 q PM with evening meal, x 1 week, then increase to 2 q Pm x 1 week, then increase to 3 q PM #90 (Ninety) tablet(s) Refills: 11 I gave him a RX card too.

**Lumbar radiculopathy** to be sure he has not worsened in his degenerative changes, esp. given his sensory deficits above, will re-check MR; has been 1 year since last ; allergic to fish/iodine, so will defer myelogram .  
RADIOLOGY: I have ordered MRI of the Lumbar Spine without contrast. Will get 5/14 EMG results, too.

Orders:

72148 MRI/spinal, lumbar, w/o contrast (Send-Out)

**Numbness** from radic? No PN on exam. Await MR.

**Follow-up:** A follow-up appointment will be scheduled for 3 weeks from now Patient evaluation by Paul Buechel, MD, (Board certified neurologist)

Orders: We had a very extensive 45+ minute visit; all questions answered.

**Davis, Arthur C.** **REDACTED**

1 of 3

Office/Outpatient Visit

Visit Date: Tue, Dec 2, 2014 11:45 am

Provider: Paul Buechel, MD (Assistant: Ricky Peeple, )

Location: KCA Medical Group PLLC

Electronically signed by Paul Buechel, MD on 12/17/2014 11:22:44 AM

Printed on 12/22/2014 at 10:52 am.

## **SUBJECTIVE:**

### **CC:**

Mr. Davis is a 51 year old Black or African American male. This is a follow-up visit.

### **HPI:**

Mr. Davis presents for a follow up evaluation of low back pain.. Nothing relieves the symptoms. Symptoms are worse with exertion. He estimates that the frequency of this symptom is varies. The typical duration of an episode is variable.

Neurontin makes him feel bad mentally, not helping pain; quit it after 3 wks.

Mr. Davis presents for a follow up evaluation of causalgia of lower limb.. Symptoms are better with lying perfectly still. Symptoms are worse with exertion. He estimates that the frequency of this symptom is varies. The typical duration of an episode is variable.

Mr. Davis presents for a follow up evaluation of lumbar radiculopathy.. Symptoms are better with meds. Symptoms are worse with exertion. He estimates that the frequency of this symptom is daily. The typical duration of an episode is variable.

Numbness is also noted.

### **ROS:**

**CONSTITUTIONAL:** Positive for **fatigue, night sweats and unintentional weight gain**. Negative for chills, fever or unintentional weight loss.

**EYES:** Positive for **use of glasses or contacts**. Negative for blurred vision, eye pain or photophobia.

**E/N/T:** Negative for ear pain, diminished hearing, tinnitus, use of dentures, hoarseness and tooth pain.

**CARDIOVASCULAR:** Negative for dizziness, palpitations, pedal edema and tachycardia.

**RESPIRATORY:** Positive for **frequent wheezing**. Negative for recent cough or dyspnea.

**GASTROINTESTINAL:** Positive for **constipation**. Negative for abdominal pain, acid reflux symptoms, dysphagia, diarrhea, heartburn, nausea, vomiting or odynophagia.

**GENITOURINARY:** Negative for dysuria, lesions on external genitalia, hematuria, high risk sexual behavior, history of recurrent UTIs, nocturia, polyuria and urinary incontinence.

**MUSCULOSKELETAL:** Positive for **arthralgias, back pain, joint stiffness and limb pain**. Negative for myalgias.

**INTEGUMENTARY:** Negative for rash.

**NEUROLOGICAL:** Positive for **confusion, dizziness, generalized pain, headaches, memory loss, paresthesias and weakness**. Negative for ataxia, fainting, nausea/vomiting, seizures, speech disorder, tremor or vertigo.

**HEMATOLOGIC/LYMPHATIC:** Negative for easy bruising, excessive bleeding and history of blood transfusion.

**ENDOCRINE:** Positive for **temperature intolerances, polydipsia and excessive sweating**. Negative for hair loss.

**ALLERGIC/IMMUNOLOGIC:** Positive for **seasonal allergies and urticaria**. Negative for risk factors for HIV.

**PSYCHIATRIC:** Positive for **anxiety**.

### **PMH/FMH/SH:**

#### **Past Medical History:**

**Asthma, Automobile accident with injuries,**

**Chronic back pain,**

**Depression**

**Hypertension**

#### **Surgical History:**

**rotator cuff both shoulders 2014**

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**Davis, Arthur C.** [REDACTED]

Office/Outpatient Visit

Visit Date: Tue, Dec 2, 2014 11:45 am

Provider: Paul Buechel, MD (Assistant: Ricky Peeple, )

Location: KCA Medical Group PLLC

Electronically signed by Paul Buechel, MD on 12/17/2014 11:22:44 AM

Printed on 12/22/2014 at 10:52 am.

**Allergies:**

No Known Drug Allergies.

**Current Medications:**

Last Reviewed on 9/15/2014 02:06 PM by Campbell, Gretchen H.

Gralise 600mg Tablet take 1 q PM with evening meal, x 1 week, then increase to 2 q Pm x 1 week, then increase to 3 q PM

Amlodipine 10mg Tablet

Bystolic 10mg Tablet

Celebrex 200mg Capsules

Citalopram Hydrobromide 20mg Tablet 1 po q day

Cymbalta 30mg Capsules, Delayed Release

Omeprazole 20mg Capsules, Extended Release

**OBJECTIVE:**

**Vitals:**

Current: 12/2/2014 11:49:14 AM

Ht: 6 ft, 0 in

BP: 142/84 mm Hg (right arm, sitting); P: 88 bpm; R: 20 bpm

**Exams:** MR L-sp shows L2-3 bulge, & mild L nf stenosis; L3-4 bulge with mild bilat nf; L4-5 shows bulge, & L5-S1 also, with marked L facet changes at the latter.

GENERAL: well developed, well nourished, in no apparent distress head normocephalic atraumatic

EYES: lids and conjunctiva are normal; pupils and irises are normal; fundoscopic exam shows normal optic discs

MUSCULOSKELETAL: digits/nails: no clubbing, cyanosis, or evidence of ischemia or infection; normal gait;

SKIN: no ulcerations, lesions, rashes or induration; skin is dry

**NEUROLOGIC:**

Mental Status: Alert and oriented x 3; Speech is fluent cranial nerves II-XII intact;

Motor exam: 5/5 bilateral upper and lower extremities;

Tone is normal Tremors negative Reflexes: 2/4 DTR's elicited in biceps, triceps, brachioradialis, patellar, and ankle jerks

Sensation: has reduced R L4 & S1 dermatomes to sharp.;

Coordination: Finger-to-nose intact. Gait: see musculoskeletal exam above.

PSYCHIATRIC: alert and oriented x 3; appropriate affect and demeanor; tender over lower L-spine, with + L paravertebral spasm. SLR's OK.

**ASSESSMENT:**

724.2 Low back pain

DDx:

355.71 Causalgia of lower limb

DDx:

722.10 Lumbar radiculopathy

DDx:

782.0 Numbness

DDx:

**PLAN:**

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**Davis, Arthur C.** [REDACTED]

Office/Outpatient Visit

**Visit Date:** Tue, Dec 2, 2014 11:45 am

**Provider:** Paul Buechel, MD (Assistant: Ricky Peeple, )

**Location:** KCA Medical Group PLLC

Electronically signed by Paul Buechel, MD on 12/17/2014 11:22:44 AM  
Printed on 12/22/2014 at 10:52 am.

**Low back pain** disc'd MRI, no surgical lesion, etc., & we need PT , with L-traction, etc.

**REFERRALS:** Referral initiated to physical therapy ( Results Physiotherapy ).

Orders:

RFPT Physical Therapist Referral (Send-Out)

**Causalgia of lower limb** Gralise stopped. Cymbalta & Celebrex continues.

**Lumbar radiculopathy** as above.

**Numbness** unchanged.

Orders: F/U 2 mos.

**Other Patient Education Handouts:**

Acute Low Back Pain

RPT is a registered trademark of the American Medical Association.



## Premier Radiology Cool Springs

A member of the Saint Thomas Imaging Network.

Premier Radiology Cool Springs \* 3310 Aspen Grove Drive, Suite 101 \* Franklin, TN 37067  
Phone: (615)771-0171 \* Fax: (615)234-1501

Name:	ARTHUR DAVIS	Exam Date:	11/6/2014
Patient ID:	1000977943	Referrer:	Paul Buechel, MD
Secondary ID:	REDACTED	2nd Referrer:	
DOB:	REDACTED	3rd Referrer:	
Acc#:	3820858		

**PROCEDURE: MRI LUMBAR SPINE WITHOUT CONTRAST**

**TECHNIQUE:** Magnetic resonance imaging of the lumbar spine was performed using standard pulse sequences without contrast material. CPT 72148

**HISTORY:** Lumbago, Causalgia of lower limb, Displaced lumbar intervertebral disc. Patient complains of lumbago and bilateral feet burning for over one year. No recent trauma, and no previous surgery of lumbar spine. 724.2 Lumbago 722.10 Displaced lumbar intervertebral disc

**COMPARISONS:** November 6, 2013.

**FINDINGS:**

5 lumbar type vertebral segments are assumed for the purpose of this dictation with the conus terminating at L1. There is no lumbar malalignment. Mild degenerative marrow findings at L3-L4. No additional lumbar marrow signal abnormality is appreciated. Review of the visualized retroperitoneal structures is unremarkable.

There are incompletely imaged degenerative findings in the lower thoracic spine with probable associated stenotic changes at T10-T11 asymmetric toward the RIGHT based on provided sagittal images.

L1-2: No significant abnormality.

L2-3: Minimal disc bulge favoring the LEFT mildly narrowing the LEFT foramen. No central, lateral recess, or RIGHT foraminal stenosis.

L3-4: Spondylosis and disc desiccation. Circumferential disc bulge with mild facet arthropathy. Slight effacement of the ventral thecal sac without canal or lateral recess stenosis. Mild bilateral foraminal stenosis, slightly favoring the RIGHT.

L4-5: Mild disc bulge and bilateral facet arthropathy. Effacement of the thecal sac without canal or lateral recess stenosis. No significant foraminal stenosis.

L5-S1: Mild disc bulge. Facet arthropathy markedly asymmetric toward the LEFT area no canal, lateral recess, or RIGHT foraminal stenosis. Facet related LEFT foraminal stenosis which appears mild.

Other: None.

**IMPRESSION:**

1. Scattered lumbar degenerative and stenotic findings as detailed in the body of the report without more than mild stenosis at any level. Please see above for full description.
2. Incompletely imaged degenerative findings in the lower thoracic spine with probable associated stenosis at T10-T11 asymmetric toward the RIGHT.





# Premier Radiology Cool Springs

Affiliate of the Saint Thomas Imaging Network

Premier Radiology Cool Springs \* 3310 Aspen Grove Drive, Suite 101 \* Franklin, TN 37067  
Phone: (615)771-0171 \* Fax: (615)234-1501

Name:	ARTHUR DAVIS	Exam Date:	11/6/2014
Patient ID:	1000977943	Referrer:	Paul Buechel, MD
Secondary ID:	REDACTED	2nd Referrer:	
DOB:	REDACTED	3rd Referrer:	
Acc#:	3820858		

W8:PMJTN-WK01

Thank you for allowing us to participate in the care of this patient.

Electronically Signed By Jeffrey Huggett, M.D. on 11/6/2014 12:15:43 PM CTZ

Direct Line (615)986-6088

**aetna** PO Box 14560  
Lexington, KY 40512-4560  
800-954-1779

LEE

Facsimile Transmittal Sheet

To:	From:
Dr. Steven Nyquist	Aetna Disability
Employer:	Date:
Dell Inc.	11/06/2014
Fax Number: 615-771-1109	CLAIM NUMBER:
	9452367
Phone number:	Sender's Phone Number:
	954-693-2227
	Sender's FAX Number:
	1-866-667-1987
Re: MR. ARTHUR DAVIS	Total No. of Pages including Covers:
Date of Birth: REDACTED	

Urgent ☐ Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle ☐

I am the Employer Managed with Aetna handling Long Term Disability Benefits for the above patient. In order for us to continue Long Term Disability benefits, we need to obtain objective medical data to support the claim.

Please provide the following information:

Progress notes from 08/01/2014 to present with objective exam findings.

Please provide current treatment plan:

Last office visit: Next scheduled office visit:

Return to work plan:

Does your patient currently have work capacity? Yes ☐ No ☐

Restrictions:

Anticipated Full Duty return to work date:

Physician Signature: Date:

PLEASE PROVIDE MEDICAL INFORMATION BY: ASAP

Your prompt response is necessary in order to avoid termination of your patient's claim.

Disclaimer:

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you received this communication in error, please notify the sender at the phone number above.

NOTICE TO RECIPIENT(S) OF INFORMATION:

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the

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<b>aetna</b> Behavioral Health Clinician Statement		
Patient Name	Provider Name	Clinical Manager Name
Patient Year of Birth	Provider Telephone Number	Clinical Manager Telephone Number
Patient Case Number	Provider Fax Number	Clinical Manager Fax Number
Claim Number: 9452367		
Patient Occupation: Inside Sales Account Mgmt. III		

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Fax: 1-866-667-1987

Do you currently support your patient being out work? ☐ Yes ☐ No

**Diagnostic Impressions**

Primary Diagnosis(es) Preventing Work (DSM V Code)	Mild	Moderate	Severe	Other/Specifiers

**Patient's Current Progress:** ☐ Improved ☐ Stable ☐ Regressed

The patient has experienced the following barriers to returning to work:

- ☐ Inability to work demands ☐ Conflicts with supervisor ☐ Anticipation of relapse ☐ Recent unfavorable work evaluation  
☐ Dissatisfaction with the job ☐ Medication complications ☐ Medical/Physical Complications ☐ Other: \_\_\_\_\_

**Risks to Self/Others**

1. Current suicidal ideation? ☐ Yes ☐ No If Yes, please describe phantasies:  
 2. Current homicidal ideation? ☐ Yes ☐ No If Yes, please describe phantasies:  
 3. Have you and the patient agreed upon measures to be taken should the need for such measures become imminent? ☐ Yes ☐ No If Yes, please describe:  
 4. Is the patient able to report reasons for not harming self/others? ☐ Yes ☐ No If Yes, please describe:

**Emotional Functioning**

1. Emotional state/mood status during exam (Describe affect, mood, range, stability, congruency with content).  
 2. Was the patient was fearful, was it appropriate to the content being discussed? ☐ Yes ☐ No, please explain:  
 3. Requires assistance to complete self? ☐ Yes ☐ No If Yes, please describe:  
 4. Panic attacks?  
     a. Symptoms reported: \_\_\_\_\_  
     b. Frequency of panic attacks/Duration of each attack: \_\_\_\_\_  
     c. Interventions used: \_\_\_\_\_  
     d. Panic attack, ever observed in exam? ☐ Yes ☐ No If Yes, please describe:

**Additional Examination Findings/Notes**

WKAB

GR-6037 (2-10-1)



Page 1 of 1  
B-P00

Claim Number: 9452367

Patient Name	Provider Name	Clinical Manager Name
--------------	---------------	-----------------------

**Cognitive Functioning**

1. Able to follow a three step command? ☐ Yes ☐ No, please provide exam details:

2. Able to perform five operations of Block 7's or 3's? ☐ Yes ☐ No, please provide exam details:

3. Memory Functions: ☐ Digit span forward = ☐ Digit span backwards = ☐ 4 unrelated words after 5 minutes  
☐ Other measurement(s):

4. Applied focus and concentration in session for periods of: ☐ 30-60 min. ☐ 15-30 min. ☐ 5-10 min. ☐ Less than 5 min.

5. Expressed higher order circumstances and responded to direct questions appropriately? ☐ Yes ☐ No, please describe:

6. Reasoning and/or Judgment: ☐ Within normal limits ☐ Impaired, please describe:

7. Are psychotic symptoms present? (Delusions, hallucinations) ☐ Yes ☐ No If Yes, please describe:

8. Was a mini mental status exam completed? ☐ Yes ☐ No If Yes, please provide score:

Additional Examination Findings/Notes

**Behavioral Observations**

1. Behaviors observed during exam. Please provide specific details:

2. Psychomotor activity: ☐ Unremarkable ☐ Impaired, please describe:

3. Presented with appropriate dress and hygiene in session? ☐ Yes ☐ No, please describe:

4. Difficulty with impulse control? ☐ Yes ☐ No Please describe:

5. Speech: ☐ Normal ☐ Stuttered ☐ Pressured ☐ Stammering ☐ Loud ☐ Soft ☐ Over Productive ☐ Under Productive

Additional Examination Findings/Notes

**Activities of Daily Living**

1. Is patient currently performing: ☐ Volunteer Work ☐ Attending School ☐ Self-Employed  
☐ Work at a Lesser Demanding Job ☐ No Work Activities in Any Capacity

2. Significant weight/appearance changes? ☐ Yes ☐ No Caloric intake within (Time frame)

3. Sleep disturbances? ☐ Yes ☐ No Please describe:

4. Socialization problems? ☐ Yes ☐ No Please describe:

5. Obtains/maintains residence? ☐ Yes ☐ No Performs routine shopping? ☐ Yes ☐ No Pays bills? ☐ Yes ☐ No

6. Is patient able to safely operate an automobile or other motorized vehicles? ☐ Yes ☐ No, please describe:

7. What does your patient do on a daily basis?

WKAB  
GR-6817 (9-14)

Page 1 of 1  
R-PCD



Claim Number: 9452367

Patient Name	Provider Name	Clinical Manager Name
--------------	---------------	-----------------------

Treatment

	Start Date	End Date	Days Per Week	Frequency	Last Visit	Next Visit
<input type="checkbox"/> Inpatient Care						
<input type="checkbox"/> Partial Hospitalization Programs						
<input type="checkbox"/> Intensive Outpatient (IOP)						
<input type="checkbox"/> Outpatient Psychotherapy						
<input type="checkbox"/> Medication Management						

Medications

1. Please list all current medications.

2. Any recent changes in medications? ☐ Yes ☐ No If Yes, please describe.

3. Medication side effects? ☐ Yes ☐ No If Yes, please describe.

Additional Examination/Findings/Notes.

Referrals

1. Have you referred your patient to any other providers? ☐ Yes ☐ No If Yes, please provide name and contact information.

2. Have you recommended that your patient stay home from work on disability? ☐ Yes ☐ No

3. Please specify the recommended Start Date / / End Date / /

Claimant Return To Work Status

1. Is your patient:  
☐ Able to return to work FULL DUTY without modification. Full Duty release to return to work date: / /

2. If your patient is not returning to work to his/her occupation, what capacity does he/she have to work at a different occupation?

3. What are the duties related to your patient's occupation that he/she is able to perform at this time?

4. Can your patient volunteer or work part time? ☐ Yes ☐ No If Yes, please indicate volunteer or part time with start date, number of hours per day, days per week, and duration of the limitations and restrictions. Please provide any other modifications for your patient to return to work.

5. Can your patient participate in vocational rehabilitation counseling? ☐ Yes ☐ No, please explain.

\*Please attach the most recent office notes\*

Signature/Exam Date	Date Exam Completed
Print Name	Date Form Completed
Credentials	

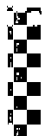
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title I from requesting or requiring genetic information of an individual or family member of the individual, except as specifically authorized by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member carries or has had a genetic predisposition to a disease, and genetic information that is also carried by an individual or an individual's family member or an entity's family history held by an individual or family member including a written reproductive decision. Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.

WVAB

CR-0017 (2-14)

Page 1 of 1  
R-POD





**aetna**<sup>SM</sup>

## Fax Message

To: Dr. Steven Nyquist

Fax: 615-771-1109

From: Lee, Shawndra E

Date: 11/6/2014 1:59 PM

Pages: 1 of 5 (including this page)

Subject: Re: Arthur Davis **REDACTED**

*Need Signed  
Authorization from  
Patient*

**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.



LEE

Facsimile Transmittal Sheet

To:	From:
Dr. Steven Nyquist	Aetna Disability
Employer:	Date:
Dell Inc	11/06/2014
Fax Number: 615-771-1109	CLAIM NUMBER:
	9452367
Phone number:	Sender's Phone Number:
	854-691-2227
	Sender's FAX Number:
	1-866-667-1987
Re: MR. ARTHUR DAVIS	Total No. of Pages including Cover: 5
Date of Birth: REDACTED	

Urgent For Review Please Comment Please Reply Please Recycle

I am the Benefit Manager with Aetna handling Long Term Disability Benefits for the above patient. In order for us to continue Long Term Disability benefits, we need to obtain objective medical data to support the claim.

Please provide the following information:

Progress notes from 08/01/2014 to present with objective exam findings.

Please provide current treatment plan: \_\_\_\_\_

Last office visit \_\_\_\_\_ Next scheduled office visit \_\_\_\_\_

Return to work plan:

Does your patient currently have work capacity? Yes \_\_\_\_\_ No \_\_\_\_\_

Restrictions: \_\_\_\_\_

Anticipated Full Duty return to work date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE PROVIDE MEDICAL INFORMATION BY: ASAP

Your prompt response is necessary in order to avoid termination of your patient's claim.

Disclaimer:

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you received this communication in error, please notify the sender at the phone number above.

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**aetna** Behavioral Health Clinician Statement

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
FAX: 1-800-667-1987

Patient Name	Provider Name	Clinical Manager Name
Patient Year of Birth	Provider Telephone Number	Clinical Manager Telephone Number
Patient Case Number	Provider Fax Number	Clinical Manager Fax Number
Claim Number: 9452367		
Patient Occupation:		
Inside Sales Account Mgmt III		

Do you currently support your patient being *out* work? ☐ Yes ☐ No

**Diagnostic Impressions**

Primary (Diagnostic) Preventing Work (DSM V Code)	Mild	Moderate	Severe	Other Specifiers

Patient's Current Progress: ☐ Improved ☐ Stable ☐ Regressed

The patient has expressed the following barriers to returning to work:

- ☐ Increases in work demand    ☐ Conflicts with supervisor    ☐ Anticipation of relapse    ☐ Recent unfavorable work evaluation  
☐ Dissatisfaction with the job    ☐ Medication complications    ☐ Medical/Physical Complications    ☐ Other: \_\_\_\_\_

**Risk to Self/Others**

1. Current suicidal ideation? ☐ Yes ☐ No If Yes, please describe plan/intent: \_\_\_\_\_
2. Current homicidal ideation? ☐ Yes ☐ No If Yes, please describe plan/intent: \_\_\_\_\_
3. Have you and the patient agreed upon measures to be taken should the need to harm self/others become imminent? ☐ Yes ☐ No If Yes, please describe: \_\_\_\_\_
4. Is the patient able to report reasons for not harming self/others? ☐ Yes ☐ No If Yes, please describe: \_\_\_\_\_

**Emotional Functioning**

1. Emotional/behavioral status during exam (Describe affect, mood, range, lability, congruency with content): \_\_\_\_\_
2. If the patient was fearful, was it appropriate to the content being discussed? ☐ Yes ☐ No, please explain: \_\_\_\_\_
3. Requires assistance to compose self? ☐ Yes ☐ No If Yes, please describe: \_\_\_\_\_
4. Panic attacks? ☐ Yes ☐ No
  - a. Symptoms reported: \_\_\_\_\_
  - b. Frequency of panic attacks/duration of each attack: \_\_\_\_\_
  - c. Intervention used: \_\_\_\_\_
  - d. Panic attack ever observed to exam? ☐ Yes ☐ No If Yes, please describe: \_\_\_\_\_

**Additional Examination Findings/Notes**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WKAB  
CR-65317 (8-14) J

Page 1 of 1  
R-POB





Claim Number: 9452367

Patient Name	Provider Name	Clinical Manager Name
--------------	---------------	-----------------------

**Cognitive Functioning**

1. Able to follow a three step command? ☐ Yes ☐ No, please provide exam details:

2. Able to perform five operations of Serial 7's or 3's? ☐ Yes ☐ No, please provide exam details:

3. Memory Function: ☐ Digit span forward = ☐ Digit span backward = ☐ 4 unrelated words after 5 minutes  
☐ Other measurement(s):

4. Applied focus and concentration in session for periods of: ☐ 30-60 min. ☐ 15-30 min. ☐ 5-15 min. ☐ Less than 5 min.

5. Expressed his/her current circumstances and responded to direct questions appropriately? ☐ Yes ☐ No, please describe:

6. Reasoning and/or Judgment: ☐ Within normal limits ☐ Impaired, please describe:

7. Are psychotic symptoms present? (Delusions, hallucinations) ☐ Yes ☐ No If Yes, please describe:

8. Was a mini mental status exam completed? ☐ Yes ☐ No If Yes, please provide score:

Additional Examination Findings/Notes:

**Behavioral Observations**

1. Behaviors observed during exam. Please provide specific details:

2. Psychomotor activity: ☐ Unremarkable ☐ Impaired, please describe:

3. Presented with appropriate dress and hygiene in session? ☐ Yes ☐ No, please describe:

4. Difficulty with impulse control? ☐ Yes ☐ No Please describe:

5. Speech: ☐ Normal ☐ Stunned ☐ Pressured ☐ Stammering ☐ Loud ☐ Soft ☐ Over Productive ☐ Under Productive

Additional Examination Findings/Notes:

**Activities of Daily Living**

1. Is patient currently performing: ☐ Voluntary Work ☐ Attending School ☐ Self-Employed  
☐ Work at a Lesser Demanding Job ☐ No Work Activities in Any Capacity

2. Significant weight/body path changes? ☐ Yes ☐ No Gain/loss within (Time frame)

3. Sleep disturbances? ☐ Yes ☐ No Please describe:

4. Socialization problems? ☐ Yes ☐ No Please describe:

5. Owns/Maintains residence? ☐ Yes ☐ No Performs routine shopping? ☐ Yes ☐ No Pays bills? ☐ Yes ☐ No

6. Is patient able to safely operate an automobile or other motorized vehicle? ☐ Yes ☐ No, please describe:

7. What does your patient do on a daily basis?

WKAB  
GR-68317 (P-14) J



Page 1 of 1  
R-POD

Claim Number: 9452367

Patient Name	Provider Name	Clinical Manager Name
--------------	---------------	-----------------------

Treatment	Start Date	End Date	Days Per Week	Frequency	Last Visit	Next Visit
<input type="checkbox"/> Inpatient Care						
<input type="checkbox"/> Partial Hospitalization Programs						
<input type="checkbox"/> Intensive Outpatient (IOP)						
<input type="checkbox"/> Outpatient Psychotherapy						
<input type="checkbox"/> Medication Management						

**Medications**

1. Please list all current medications.

2. Any recent changes in medications? ☐ Yes ☐ No If Yes, please describe:

3. Medication side effects? ☐ Yes ☐ No If Yes, please describe:

Additional Examination Findings/Notes:

**Referrals**

1. Have you referred your patient to any other providers? ☐ Yes ☐ No If Yes, please provide name and contact information:

2. Have you recommended that your patient stay home from work or school? ☐ Yes ☐ No

3. Please specify the recommended Start Date: / / End Date: / /

**Claimant Return To Work Status**

1. Is your patient:

☐ Able to return to work FULL DUTY without modification. Full Duty release to return to work date: / /

2. If your patient is not returning to work to his/her occupation, what specialty does he/she have to work at a different occupation?

3. What are the restrictions to your patient's occupation that he/she is able to perform at this time?

4. Can your patient volunteer or work part time? ☐ Yes ☐ No If Yes, please indicate volunteer or part time with start date, number of hours per day, days per week, and duration of the limitations and restrictions. Please provide any other modifications for your patient to return to work.

5. Can your patient participate in vocational rehabilitation counseling? ☐ Yes ☐ No, please explain.

\*Please attach the most recent office notes\*

Signature/Exam Date	
Signature	Date Exam Completed
Print Name	Date Form Completed
Credentials	

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title I from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the health of an individual or an individual's family member sought as the covered person's worker, and genetic testing of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member seeking infertile reproductive services. Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.

WKAB

OR-58317 (5-14) J

Page 1 of 1  
R-POD



Group # 0476626

Claim # 9452367

Social Security Administration  
RETIREMENT, SURVIVORS, AND DISABILITY INSURANCE  
Notice of Disapproved Claim

443  
504/DRJ

ARTHUR C DAVIS JR

**REDACTED**

MURFREESBORO TN 37128

Date: 09/05/14

Claim Number: **REDACTED**

We are writing about your claim for Social Security disability benefits. Based on a review of your health problems you do not qualify for benefits on this claim. This is because you are not disabled under our rules.

We have enclosed information about the disability rules and more details about the decision on your claim.

ABOUT THE DECISION

Doctors and other trained staff looked at your case and made this decision. They work for your State but used our rules.

Please remember that there are many types of disability programs, both government and private, which use different rules. A person may be receiving benefits under another program and still not be entitled under our rules. This may be true in your case.

IF YOU DISAGREE WITH THE DECISION

If you disagree with this decision, you have the right to appeal. We will review your case and consider any new facts you have. A person who did not make the first decision will decide your case.

- \* You have 60 days to ask for an appeal.
- \* The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.
- \* You must have a good reason for waiting more than 60 days to ask for an appeal.
- \* You have to ask for an appeal in writing. We will ask you to complete a form SSA-561-U2, called "Request for Reconsideration." You may contact one of our offices or call 1-800-772-1213 to request this form. Or you may complete this form online at <http://www.socialsecurity.gov/disability/appeal>. Contact one of our offices if you want help.
- \* In addition, you should complete a "Disability Report - Appeal" to tell us about your medical condition since you filed your claim. You may contact one of our offices or call 1-800-772-1213 to request this form. Or, you may complete this report online after you complete the online Request for Reconsideration.

NEW APPLICATION

You have the right to file a new application at any time, but filing a new

0929140020

Form SSA-L443-U3 (7-93)

application is not the same as appealing this decision. If you disagree with this decision and you file a new application instead of appealing:

- \* you might lose some benefits, or not qualify for any benefits, and
- \* we could deny the new application using this decision, if the facts and issues are the same.

So, if you disagree with this decision, you should ask for an appeal within 60 days.

#### IF YOU WANT HELP WITH YOUR APPEAL

You can have a friend, lawyer, or someone else help you. There are groups that can help you find a lawyer or give you free legal services if you qualify. There are also lawyers who do not charge unless you win your appeal. Your local Social Security office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it. And if you hire a lawyer, we will withhold up to 25 percent of any past due Social Security benefits to pay toward the fee.

#### OTHER BENEFITS

Based on the application you filed, you are not entitled to any other benefits, besides those you may already be getting. In the future, if you think you may be entitled to other benefits you will need to apply again.

#### IF YOU HAVE ANY QUESTIONS

If you have any questions, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at (866) 593-3112. We can answer most questions over the phone. You can also write or visit any Social Security office. The office that serves your area is located at:

2836 SAINT PATRICK CT  
MURFREESBORO TN 37128-9934

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly.

Social Security Administration

#### RULES FOR SOCIAL SECURITY DISABILITY

You must meet certain rules to qualify for Social Security disability benefits:

##### FOR DISABLED WORKER'S BENEFITS:

You must have the required work credits and your health problems must:

- \* keep you from doing any kind of substantial work (described below), and
- \* last, or be expected to last, for at least 12 months in a row, or result in death.

##### FOR DISABLED CHILD'S BENEFITS:

You must be age 18 or older and your health problems must:

0929140020  
Page: 91240020

- \* begin before age 22 OR you must become disabled again within 7 years after the month that your earlier period of disability ended and
- \* keep you from doing any kind of substantial work (described below), and
- \* last, or be expected to last, for at least 12 months in a row, or result in death.

FOR DISABLED WIDOW'S, WIDOWER'S OR SURVIVING DIVORCED SPOUSE'S BENEFITS:  
You must be at least age 50, and your health problems must:

- \* keep you from doing any kind of substantial work (described below), and
- \* last, or be expected to last, for at least 12 months in a row, or result in death, and
- \* have started before the end of a special period.

The special period STARTS with the latest of:

- the month your spouse died, OR
- the month your Social Security benefits as a parent ended, OR
- the month your earlier period of widow(er)'s disability ended.

The special period ENDS at the close of the 84th month (7 years) after the month it started.

#### INFORMATION ABOUT SUBSTANTIAL WORK

Generally, substantial work is physical or mental work you are paid to do. Work can be substantial even if it is part-time. To decide if your work is substantial, we consider the nature of the job duties, the skills and experience you need to do the job, and how much you actually earn.

Usually, we find that your work is substantial if your gross earnings average over \$1070 per month after we deduct allowable amounts. This monthly amount is higher for Social Security disability benefits due to blindness.

Your work may be different than before your health problems began. It may not be as hard to do and your pay may be less. However, we may still find that your work is substantial under our rules.

If you are self-employed, we consider the kind and value of your work, including your part in the management of the business, as well as your income, to decide if your work is substantial.

Enclosures:

Explanation of Decision  
Disability Rules Factsheet

578

Page 2 9340020



File Copy - For Internal Use Only

SiteID: Dell Inc

Claim#: 9452367

Policy#: 476626

SSN: REDACTED

DOB: [REDACTED]

September 22, 2014

ARTHUR DAVIS

REDACTED

MURFREESBORO TN 37128

Dear Mr. Arthur Davis:

Since our files indicate you may be eligible for Social Security disability benefits, we believe a Social Security application on your behalf is warranted.

We are making available to you professional representatives to pursue your claim. Experience has shown that proper third-party representation throughout the entire Social Security application process greatly increases the chances of obtaining a Social Security disability award.

Allsup is a specialized claims administration company that provides a full range of Social Security assistance services to disability applicants throughout the United States and Puerto Rico. Allsup's representational services are available at absolutely no cost to you as long as you continue to receive Long Term Disability benefits from Aetna.

Their knowledge of the Social Security disability program and claims process allows them to act on your behalf from one of their field offices with minimal, if any, direct contact between you and the Social Security Administration. Many of Allsup's management personnel are former Social Security professionals; therefore, they know how frustrating the disability claims process is and their services have been specifically designed to relieve you of this burden.

Although your Long Term Disability benefit would be reduced by any Social Security disability benefits you may receive, you and your family still stand to gain some very significant financial advantages by obtaining a Social Security award (see attached page). Please review these advantages in detail-they are extremely important to you and your family, both now and in the future.

So that Allsup can begin to pursue your Social Security claim, **please sign the enclosed Form SSA-1696**, where highlighted in yellow. Please sign your name as it appears on your Social Security card and return the form as soon as possible.

If you have any questions, contact the Allsup Benefits Information Center at (888) 320-6890, or write to them at 300 Allsup Place, Belleville, Illinois 62223.

Sincerely,

AETNA  
CUSTOMER SERVICE UNIT

Enclosures

Print Letter

From: AETNA

Page: 5/6

Date: 8/15/2014 1:21:06 PM

Page 4 of 5

WKAB  
GC-1426 (2-7-13) C

Page 3



Claim Number: 9452367

aetna

Capabilities and Limitations  
Worksheet

Complete and sign this form using BLUE or BLACK ink

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: 800-354-1779  
Fax: 1-866-667-1987

Employee Name (Last, First, Middle Initial) <b>DAVIS, ARTHUR</b>		Social Security Number		Year of Birth	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Age		Control Number <b>0476626</b>	
Current Diagnosis		Medication			
Indicate the percent of the day the following activities can be performed: (Occasional 1-33% or 5-25 hrs. Frequent 34-66% or 2.6-5.0 hrs. Continuous 67-100% or 5.1-5 hrs. or More)					
Climbing	<input type="checkbox"/>	Hand Grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chasing	<input type="checkbox"/>	Fine Hand Grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	Fine Manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	Gross Manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing	<input type="checkbox"/>	Repetitive Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching above shoulder	<input type="checkbox"/>	Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forward reaching	<input type="checkbox"/>	Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying	<input type="checkbox"/>	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting	<input type="checkbox"/>				
Maximum weight patient is capable of lifting		Approved Head and Neck Movements:			
1 - 5 lbs	<input type="checkbox"/>	Stare Position	Yes	No	
6 - 10 lbs	<input type="checkbox"/>	Frequent Flexing	<input type="checkbox"/>	<input type="checkbox"/>	
11 - 20 lbs	<input type="checkbox"/>	Recurrent Rotation	<input type="checkbox"/>	<input type="checkbox"/>	
21 - 35 lbs	<input type="checkbox"/>	Can the Patient operate	Yes	No	
36 - 50 lbs	<input type="checkbox"/>	A Motor Vehicle	<input type="checkbox"/>	<input type="checkbox"/>	
51 - 75 lbs	<input type="checkbox"/>	Hazardous Materials	<input type="checkbox"/>	<input type="checkbox"/>	
76 - 100 lbs	<input type="checkbox"/>	Power Tools	<input type="checkbox"/>	<input type="checkbox"/>	
101 lbs +	<input type="checkbox"/>				
Limitations to		Exposure Limitations			
Speaking	<input type="checkbox"/>	Heat	<input type="checkbox"/>	<input type="checkbox"/>	Dust
Vision (w/aid)	<input type="checkbox"/>	Cold	<input type="checkbox"/>	<input type="checkbox"/>	Fumes
Depth Perception	<input type="checkbox"/>	Dampness	<input type="checkbox"/>	<input type="checkbox"/>	Chemicals
Hearing (w/aid)	<input type="checkbox"/>	Noise	<input type="checkbox"/>	<input type="checkbox"/>	Radiation
Total # of hours patient capable of working per day 12 <input type="checkbox"/> 8 <input type="checkbox"/> 6 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/>		Care Complete Yes <input type="checkbox"/> No <input type="checkbox"/> Next Appointment			
Additional Comments					
Physician's Signature					
Date (MM/DD/YYYY)					
Physician Name					
Specialty					
Phone Number					
Facility					
Address					

WKAB  
GC-1509-26 (7-13)

Page 1 of 2

Employee Name (Last, First, Middle Initial, Required)  
DAVIS, ARTHUR

Misrepresentation

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From: 615 791 0927

Page: 5/7

Date: 6/20/2014 9:55:32 AM

Print Letter

From AETNA

Page: 5/6

Date: 6/16/2014 1:59.32 PM

Page 4 of 5

WKAJ  
G. 124 20 0 1510

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Claim Number: 9452367

**aetna** Capabilities and Limitations Worksheet

Complete and sign the form using BLUE or BLACK ink

Acad Life Insurance Company  
P.O. Box 14560  
Lexington, KY 40512-4560  
Phone: 800-354-1779  
Fax: 1-866-567-1987

[illegible]

2/1/88  
00150076 (P-12)

Page 1 of 7



SHIRLEY ANN (DAUGHTER OF) (MRS) KIRK  
DAVE, ARTHUR

### Misrepresentation

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From: AETNA Page: 1/6 Date: 8/15/2014 1:21:06 PM

**aetna**<sup>SM</sup>

## Fax Message

*From* **To:** Dr. Yoneyama**Fax:** 6159163903*To* **From:** Greene Celestine, Wanda

866-667-1987

**Date:** 8/15/2014 2:19 PM**Pages:** ~~1 of 6 (including this page)~~ 17 pages**Subject:** Arthur Davis**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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Print Letter

From: AETNA Page: 2/6 Date: 8/15/2014 1:21:06 PM

Page 1 of 5



08/15/2014

Dr. Tad Yoneyama Heritage Medical  
2339 Millsboro Road  
Franklin TN 37069

Group Control No: C476628  
Employer: Dell inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

Dear Dr. Yoneyama:

The Dell inc. group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna). To properly evaluate their eligibility for continued disability benefits, information is needed from your office.

Please include current office and/or chart notes, along with any medical documentation you may have including, labs, blood work, physical exam, MR/x-ray and the results of any other diagnostic test from July 2014 office visit. We also ask that you complete the attached Attending Physician Statement and Capabilities and Limitations Work Sheet.

Dell inc.'s Program requires a clinical review of the medical appropriateness for your patient's work absence. Your office can fax the documents to 1-866-667-1987 or mail them to:

Aetna Life Insurance Company  
Dell inc. LTD Program  
PO Box 14560  
Lexington, KY 40512-4560

It is important to understand that if we do not receive the requested documentation by August 30, 2014 your patient's case may be closed and benefits may be terminated.

Should you have any questions regarding your claim, please call 800-354-1779 and an Aetna Customer Service Representative will be happy to assist you.

Should you have any questions regarding your claim, please call 800-354-1779 and an Aetna Customer Service Representative will be happy to assist you.

Sincerely,

SHAWN DRA LEE  
LTD BENEFIT MANAGER  
Aetna Life Insurance Company

Enclosures  
Attending Physician Statement  
Capabilities and Limitations Worksheet

8-14-2014  
see office note  
7-14-2014  
and  
forms from  
6-20-2014  
no significant  
changes  
78

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Print Letter

From: AETNA

Page: 3/6

Date: 8/15/2014 1:21:06 PM

Page 2 of 5

Claim Number 9452367

**aetna****Attending Physician Statement**

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company  
 PO Box 14560  
 Lexington, KY 40512-4560  
 Phone: 800-354-1779  
 Fax: 1-866-667-1587

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this Request for medical information. Genetic information as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assisted reproductive services. Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.

1. Patient Instructions – The Physician was complete Sections 2 through 7.  
 The Patient will complete Sections 1 and 8.  
 The Patient should also fill in their name at the top of Pages 2 and 3.

The Patient is responsible for completing this section and for ensuring that their Attending Physician completes the remainder of this statement. The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. If you have any questions, please call 800-354-1779.

(a) Control Number: 0476626

(b) Patient Name (Last, First Middle Initial): DAVIS, ARTHUR Social Security Number: REDACTED Year of Birth: REDACTED Height: REDACTED Weight (lbs): REDACTED

(c) Patient Gender: ☐ Male ☐ Female

(d) Patient Home Address (Please include Apt No., Street, Town, State, ZIP – no P.O. boxes): ☐ Check if New

(e) Mailing Address, if different from Home Address: \_\_\_\_\_

(f) Patient Employer Name/City/State: Dell Inc.

(g) Patient Telephone Number: \_\_\_\_\_ ☐ Check if New

(h) Job Title/Occupation: Inside Sales Account Mgmt. II

(i) Type of Claim: ☐ Short Term Disability ☐ Long Term Disability ☐ Worker's Compensation

**2. Physician Instructions**

The Attending Physician should complete the items below, based upon a recent examination. Attach additional documentation as needed. If you have any questions, please call 800-354-1779.  
 Please complete form in its entirety and fax to 1-866-667-1587. Pages 2 and 3 MUST be completed before faxing.

**3. Impairing Diagnosis & Treatment**

(a) For medical reasons, the patient will need to be absent from work due to a disability beginning on MM/DD/YYYY and ending on MM/DD/YYYY.

(b) Primary Diagnosis: \_\_\_\_\_ Primary ICD Code: \_\_\_\_\_  
 Secondary Diagnosis: \_\_\_\_\_ Secondary ICD Code: \_\_\_\_\_  
 Other Diagnosis: \_\_\_\_\_ Other ICD Code: \_\_\_\_\_

(c) Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date Measured (MM/DD/YYYY): \_\_\_\_\_

(d) If pregnancy related, delivery or expected due date: \_\_\_\_\_ Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_  
 Delivery Type: ☐ Vaginal ☐ Cesarean

(e) Primary Procedure: \_\_\_\_\_ Primary CPT Code: \_\_\_\_\_  
 Secondary Procedure: \_\_\_\_\_ Secondary CPT Code: \_\_\_\_\_  
 Other Procedure: \_\_\_\_\_ Other CPT Code: \_\_\_\_\_

(f) Medication(s)/Dose/Frequency: \_\_\_\_\_

(g) Is patient still under your care for this condition? ☐ Yes ☐ No Date service terminated: MM/DD/YYYY

(h) Treatment Summary: \_\_\_\_\_

(i) Office Visit Dates: First MM/DD/YYYY Last MM/DD/YYYY Next MM/DD/YYYY Frequency of appointments: \_\_\_\_\_

(j) Was patient recently hospitalized? ☐ No ☐ Yes Date hospitalized: MM/DD/YYYY Admit: MM/DD/YYYY Discharge: MM/DD/YYYY

(k) Hospital Name/City/State: \_\_\_\_\_

WKAB-CC-1406-26 (7-13) C-R-POD

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Claim Number: 9452367 Page 2

Patient Name (Last, First, Middle Initial) Required  
DAVIS, ARTHUR

## 4. History

## (a) Symptoms

(b) Date symptoms first appeared or accident happened Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

(c) Has patient ever had same or similar condition? ☐ No ☐ Yes State when and describe.(e) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown

## (f) Other Treating Physicians

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

## 5. Abilities/Limitations

(a) Patient is: Place remarks in item (d) below, if applicable.

- Competent to evidence checks and direct the use of proceeds thereof ☐ Yes ☐ No ☐ Other describe in (d)
- Able to work with others ☐ Yes ☐ No ☐ Other describe in (d)
- Able to give supervision ☐ Yes ☐ No ☐ Other describe in (d)
- Able to work cooperatively with others in group setting ☐ Yes ☐ No ☐ Other describe in (d)
- Able to do? Select one: Place remarks in item (d) below, if applicable.

☐ Heavy work activity: No limitations of functional capacity.☐ Medium work activity: Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly.☐ Light work activity: Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently.☐ Sedentary work activity: Moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. (Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.)☐ No ability to work: Severe limitation of functional capacity; incapable of manual activity.☐ Other: Place remarks in item (d) below.

(b) What medical restrictions/limitations are you placing on patient? (Activities of Daily Living, Driving, Lifting, Pulling, Pushing, and Amounts, etc.)

• Number of hours patient is capable of working in a day ☐ 12 ☐ 10 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐ 1 Hour/Day• Number of days per week patient is able to work ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week

• Date you prescribed restriction on work activities Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

• How long are these restrictions/limitations in effect? Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ ☐ No Longer• Estimated return to work date? ☐ QUOTE YYYY Modified Duty ☐ UNQUOTE YYYY Full Duty

(c) Objective findings that substantiate impairment (current laboratory, physical and/or mental status examination and other testing)

(d) Other comments

## 6. Current Status

(a) Patient has ☐ Improved ☐ Stagnated ☐ Regressed ☐ Not Applicable

(b) Is there a medical contraindication for patient to participate in Vocational Rehabilitation (job training) programs?

☐ No ☐ Yes please explain

(c) In your opinion, is your patient motivated to return to work?

## 7. Physician Information

Attending Physician's Name (Print) \_\_\_\_\_ Degree \_\_\_\_\_ Capacity \_\_\_\_\_

Address (No Street City, State ZIP Code) \_\_\_\_\_ Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Signature \_\_\_\_\_ Date (MM/DD/YYYY) \_\_\_\_\_

WKA8

DC-1486-26 (7-13) C

Claim Number: 9452367

Patient Name (Last, First, Middle Initial) Required  
DAVIS, ARTHUR

## 8. Regulation Notice

Any person who knowingly and with intent to defraud, defraud or deceive any insurer or company or other person files an application for insurance or statement of claim containing any material false information or contents, for the purpose of misleading information concerning any fact material therein commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

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Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Employee's Signature

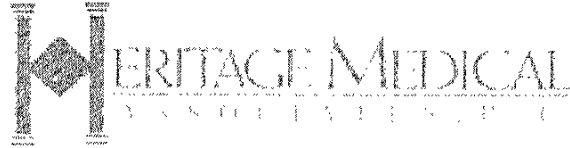
Date (MM/DD/YYYY)

WKAB 00-1500-35 (7-13)

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2339 Hillsboro Road, Suite 100  
Franklin, TN 37069  
Phone: (615) 224-1975

Arthur C Davis  
DOB: REDACTED (50 years)

Encounter Date: 07/14/2014

## History of Present Illness

The patient is a 50 year old male who presents for a follow up of chronic conditions. 6mth. needs rf on spiro lactone  
wt up 4lbs  
did not get condo b/c did not qualify  
ex-wife renting house, she offered room at her place \$500/month  
she is working 2 jobs  
son working at McDonalds  
LBP radiates down leg 6-8/10  
burning with intermittent bee sting pain  
pain doc - cymbalta caused tingling in legs  
neck and LBP, not relieved with aleve  
neuro- pamelor helped but bladder side effects could not go  
exercise walk treadmill 1hr daily  
takes tylenol and 1/2 tab tramadol 30min before treadmill  
diet not good  
1 month ago 260lbs -> 246lbs today  
some mood swings  
no chest pain/SOB/DOE/dizziness/nausea/GERD  
fall going to online MTSU computer

## History

Arthur C Davis

Patient #: 200797

DOB: REDACTED (50 years)

Friday, August 15, 2014

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**Past Medical****Insomnia****Anxiety**

**Shoulder joint pain;** Dr McGehee- dx frozen shoulder Bilaterally; MRI shows Bilateral tears, will go to Premiere ortho (not happy that reports not sent and phone called not returned from TOA); Dr Renfro LEFT 10/2013, plan RIGHT 1/2014

**GERD (gastroesophageal reflux disease)****Active asthma****Lumbar radiculopathy****Degenerative lumbar disc**

**Paresthesia;** burning all day and night, feet and lower shin off/on; worse when legs straight or sit for long time, sched for EMG 6/13/2014 Dr William Newton at M'boro Med Clinic, LBP, paresthesia worsening, no weakness/numbness, Lyrica-> after 3 days, tingle in hands/feet  
neurontin- felt stupid, still on tramadol at night

**Routine Male physical exam****Dyspnea****Herpes simplex type 2 infection;** 12/2012 lab Positive HSV 2

only 5 partners, no lesions/sores in past

has had perirectal sores in past

no sex with wife x 6yrs

affair with lady 8yrs ago

**Allergic rhinitis****LBP (low back pain)****HTN (hypertension), benign****Concern about STD in male without diagnosis****Past Surgical**

Inguinal Hernia Repair: Left 1988

shoulder surgery 10/2013 LEFT shoulder Dr Renfro repair;

plan 1/31/2014 RIGHT shoulder

10/2013 short term disability from Dell

Dell offered a package- 1 wk pay for each year of service (7+yrs)

Joint Arthroscopy: Left ACL 6/2004; RIGHT knee meniscus 1989

Septoplasty (06/2012) deviated septum saw Dr Seibert ENT

Vasectomy (08/2013) M'boro Dr Snowden

**Other Medical History**

Routine general medical examination at a health care facility

Unspecified Diagnosis

Unspecified Diagnosis

Acute sinus infection

**Health Maintenance**

Annual Eye Exam glasses, eye check 2011 Eyemasters

CPE 4/2011 chol 150/73/49/86, cmp normal, tsh 0.72, psa 0.58, wbc 3.8, hct 48.7%, plt 322; Td 5/2005

Echocardiogram (02/2012) EF 65%, mild LVH

**Allergy**

Mobic \*ANALGESICS - ANTI-INFLAMMATORY\*: Dizziness

WASPS

NUTS

FISH

EGGS: Hives

**Medications**

Omeprazole (20MG Capsule DR 1 Oral two times daily, Taken starting 07/19/2013) Active - Hx Entry.

CeleBREX (200MG Capsule 1 Oral daily, Taken starting 01/13/2014) Active - Hx Entry.

Zyrtec Allergy (10MG Capsule, 1 Oral daily, Taken starting 11/21/2011) Active.

Bystolic (10MG Tablet, 1 Oral daily, Taken starting 01/15/2014) Active.

Flonase (50MCG/ACT Suspension, 1 Nasal two times daily, as needed, Taken starting 01/22/2014) Active.

Advair Diskus (250-50MCG/DOSE Aero Pow Br Act, 1 Inhalation two times daily, Taken starting 07/19/2013) Active.

Lisinopril-Hydrochlorothiazide (20-25MG Tablet, 1 Oral daily, Taken starting 06/11/2014) Active.

EpiPen 2-Pak (0.3MG/0.3ML Device 1 Injection as directed, Taken starting 06/13/2012) Active - Hx Entry.

Lotrisone (1-0.05% Cream, 1 External two times daily, Taken starting 05/13/2014) Active.

CloNIDine HCl (0.1MG Tablet, 1 Oral three times daily prn SBP >160, Taken starting 01/13/2014) Active.

AmLODIPine Besylate (10MG Tablet, 1 Oral daily, Taken starting 07/12/2013) Active.

Diazepam (5MG Tablet, 1 (one) Tablet Oral at bedtime, Taken starting 01/13/2014) Active.

Dulera (200-5MCG/ACT Aerosol, 1 (one) Aerosol Inhalation two times daily, Taken starting 01/15/2014) Active.

Spirolactone (25MG Tablet 1 Oral daily) Active - Hx Entry.

Medications Reconciled.

Arthur C Davis

Patient #: 200797

DOB:

REDACTED

(50 years)

Friday, August 15, 2014

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**Social**

Tobacco use: Never smoker

Alcohol Use: Rarely drinks

Exercise History spin class 4x/week, yoga 2x/week, krav maga israeli self defense class

Living situation sold house 2/2014, looking at townhouse in M'boro 1300sqft 3BR 2 car garage \$135k; did not get condo b/c did not qualify; 7/2014 ex-wife renting house, she offered room at her place \$500/month, she is working 2 jobs; son working at McDonalds

Stress Issues: Marital difficulties 3/2013 GF's Dad is PI, may do some work with him, GF on disability, hypersense of smell, gets sick to smells, was CFP, reaction- shaking, dizzy, she is going through divorce

Work Status Dell, plans to leave in Jan 2013 to join friend starting company- security/body guards; plan armed security classes in Dec 2012 and israeli self defense class krav maga; 3/2013 now plans to stay at Dell 4-5yrs; fall 2014 going to online MTSU computer

Marital status wife - planning on divorce, after she went on a retreat 3/2012- will file after house refinanced in 2013; wife filed divorce 2/15/2013, court June 4,2013; patient moved to M'boro 2/16/2013; divorce final 6/2013, house on market; 1/2014 22yo daughter turned down job at Dell and Jackson National, 17yo son not doing well in high school  
Caffeine Use occasionally**Family**

Other Relatives: aunt breast ca, aunt pancreatic ca, aunt ovarian ca

Sister HTN, Asthma

Mother: Hypertension, CHF

Father: Deceased @ 31yo MVA

**Review of Systems****General:** Not Present- Chills, Fatigue, Feeling Sick, Fever and Night Sweats.**Skin:** Not Present- Dryness, Itching, Nail Changes, New Lesions and Rash.**HEENT:** Present- Headache and Wears glasses/contact lenses. Not Present- Visual Disturbances, Hearing Loss, Ear Pain, Ringing in the Ears, Vertigo, Runny Nose, Nasal Congestion, Seasonal Allergies and Sore Throat.**Neck:** Not Present- Neck Pain, Neck Stiffness and Swollen Glands.**Respiratory:** Present- Shortness of Breath. Not Present- Cough and Wheezing.**Cardiovascular:** Present- Abnormal Blood Pressure. Not Present- Chest Pain, Edema, Leg Cramps and Palpitations.**Gastrointestinal:** Present- Heartburn and Nausea. Not Present- Abdominal Pain, Change in Bowel Habits, Constipation, Diarrhea, Dysphagia, Jaundice, Rectal Bleeding and Vomiting.**Male Genitourinary:** Not Present- Difficulty with Erection, Dysuria, Hematuria, Nocturia and Polyuria.**Musculoskeletal:** Present- Back Pain and Joint Pain. Not Present- Decreased Range of Motion, Muscle Cramps, Muscle Weakness and Myalgia.**Neurological:** Present- Headaches, Numbness and Paresthesias. Not Present- Dizziness, Focal Neurological Symptoms, Seizures and Syncope.**Psychiatric:** Present- Mood changes (HIGH stress level). Not Present- Anxiety, Depression, Insomnia, Memory Loss, Panic Attacks and Trouble Falling Asleep.**Endocrine:** Not Present- Appetite Changes and Libido Change.**Hematology:** Not Present- Abnormal Bleeding, Easy Bruising and Painful Lymph Nodes.**Vitals**

07/14/2014 10:25 AM

**Weight:** 246 lb **Height:** 72 in**Body Surface Area:** 2.38 m<sup>2</sup> **Body Mass Index:** 33.36 kg/m<sup>2</sup>**Temp:** 98.3 °F (Oral)**BP:** 144/100 (Manual)

Arthur C Davis

Patient #: 200797

DOB: REDACTED (50 years)

Friday, August 15, 2014

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## Physical Exam

### General

**Mental Status** - Alert. **General Appearance** - Cooperative and Well groomed. **Build & Nutrition** - Well nourished and Well developed (black male). **Posture** - Normal posture. **Hydration** - Well hydrated.

### Integumentary

**Global Assessment:** Examination of related systems reveals - No lesions or abnormal redness of the oropharynx and Neck supple, with no palpable masses, no thyromegaly.

### Head and Neck

**Head** - normocephalic, atraumatic with no lesions or palpable masses.

#### Neck

**Global Assessment** - full range of motion and no palpable masses. no lymphadenopathy.

#### Thyroid

**Gland Characteristics** - normal size and consistency and no palpable nodules.

### Eye

**Eyeball** - **Bilateral** - Normal. **Sclera/Conjunctiva** - **Bilateral** - No Discharge or Conjunctival Injection. **Pupil** - **Bilateral** - Direct reaction to light normal, Equal and Round.

### ENMT

#### Ears

**Otoscopic Exam: Middle Ear** - **Bilateral** - Normal. **Tympanic Membrane** - **Bilateral** - Normal.

### Chest and Lung Exam

#### Auscultation:

**Breath sounds:** - Normal.

### Cardiovascular

Cardiovascular examination reveals - normal heart sounds, regular rate and rhythm with no murmurs and carotid auscultation reveals no bruits.

### Abdomen

**Palpation/Percussion:** Palpation and Percussion of the abdomen reveal - Non Tender, No Rebound tenderness, No Rigidity (guarding), No hepatosplenomegaly and Soft.

**Auscultation:** Auscultation of the abdomen reveals - Bowel sounds normal.

### Peripheral Vascular

#### Lower Extremity:

**Palpation: Temperature** - **Bilateral** - Normal. **Edema** - **Bilateral** - No edema.

### Neurologic

Neurologic evaluation reveals - alert and oriented x 3 with no impairment of recent or remote memory.

**Mental Status:** - Normal.

### Neuropsychiatric

The patient's mood and affect are described as - normal.

### Musculoskeletal

#### Global Assessment

Examination of related systems reveals - no digital clubbing or cyanosis.

Bilateral shoulders decreased ROM

#### Lymphatic

#### General Lymphatics

**Description** - Normal .

Arthur C Davis

Patient #: 200797

DOB: REDACTED (50 years)

Friday, August 15, 2014

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**Assessment & Plan****Paresthesia (782.0 | R20.2)**

**Problem Story:** burning all day and night, feet and lower shin off/on; worse when legs straight or sit for long time, sched for EMG 6/13/2014 Dr William Newton at M'boro Med Clinic, LBP, paresthesia worsening, no weakness/numbness, Lyrica-> after 3 days, tingle in hands/feet  
neurontin- felt stupid, still on tramadol at night

**Today's Impression:** likely due to radicular pain, refer to neuro

Current Plans:

**Degenerative lumbar disc (722.52 | M51.36)**

**Today's Impression:** presume mild by history; again doubt source of foot pain

Plan: as above

Current Plans:

**Lumbar radiculopathy (724.4 | M54.16)**

**Today's Impression:** doubt source of foot pain

Plan: continue ortho. f/u; agree w/ conservative measures

Current Plans:

**Anxiety (300.00 | F41.9)**

**Today's Impression:** prn valium

Current Plans:

**Insomnia (780.52 | G47.00)**

**Today's Impression:** after risks and benefits are discussed with the patient

Current Plans:

**Active asthma (493.90 | J45.998)**

**Today's Impression:** stable on current regiment since last visit

Current Plans:

**HTN (hypertension), benign (401.1 | I10)**

**Today's Impression:** monitor blood pressure, call if remains elevated; suspect stress at work/home and pain are major contributors

Current Plans:

- Started Spironolactone 25MG, 1 Tablet daily, #90, 90 days starting 07/14/2014, Ref. x3.
- Follow up in 6 months

**Allergic rhinitis (477.9 | J30.9)**

Current Plans:

*50 min spent in face to face consultation with the patient, discussion of diagnosis and risks and benefits to treatment options*

Arthur C Davis

Patient #: 200797

DOB: REDACTED (50 years)

Friday, August 15, 2014

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*MS Yoneyama MD*

*Tadayuki Yoneyama MD*

*Electronically Signed on 08/15/2014*

Arthur C Davis

Patient #: 200797

DOB:

REDACTED

(50 years)

Friday, August 15, 2014

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From: 615 791 0927 Page: 2/7 Date: 6/20/2014 9:55:32 AM

Print Letter

From: AETNA Page: 2/6 Date: 6/16/2014 1:59:31 PM

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**aetna**

06/16/2014

Dr. Ted Yarbrough Heritage Medical  
23091 Elkhorn Road  
Frisco, TX 75034Group Contract No: 0476626  
Employer: Dell Inc  
Employee: MRS. ARTHUR DAVIS  
Disability Claim Case No: 0452367

To Whom It May Concern:

The Dell Inc. group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna). To properly evaluate their eligibility for continuing disability benefits, information is needed from your office.

Please include current office and/or chart notes, along with any medical documentation you may have including, lab, blood work, physical exam, MRI/x-ray, and the results of any other diagnostic test from the last 90 days. We also ask that you complete the attached Appendix A Physician Statement and Capabilities and Limitations Worksheet.

Dell Inc.'s Program requires a clinical review of the medical appropriateness for your patient's work absence. Your office can fax the documents to 1-866-867-1097 or email them to:

Aetna Life Insurance Company  
Attn: Mr. TD Englein  
PO Box 14560  
Lexington, KY 40512-4560

It is important to understand that if we do not receive the requested documentation by July 1, 2014 your patient's case may be closed and benefits may be terminated.

Should you have any questions regarding your duties, please call 800-354-1773 and an Aetna Customer Service Representative will be happy to assist you.

Sincerely,

Wanda Green-Elders  
Senior Technical Specialist  
Aetna Life Insurance CompanyEnclosures:  
Attending Physician Statement  
Capabilities and Limitations WorksheetPO Box 14560  
Lexington, KY 40512-4560  
SHAWNDRA LEE  
STD BENEFIT MANAGER  
Phone: 800-354-1773  
Fax: 1-866-867-1097Arthur Davis  
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Print Letter

From: AETNA Page: 4/6 Date: 6/16/2014 1:59:32 PM

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Claim Number: 0452367 Page 2

Patient Name (Last, First, Middle Initial): DAVIS, ASHLEY

4. History

(a) Symptoms: Lower back pain, to the buttocks, lower pain

(b) Date symptoms first occurred or accident happened: Month 8 Day 10 Year 2013

(c) Has patient ever had same or similar condition? ☒ No ☐ Yes State when and duration.

(d) Is condition due to injury or sickness arising out of patient's employment? ☒ No ☐ Yes

(e) Other Treating Physicians:

Name Dr. Prasad Neema Specialty Ortho City Franklin State TX

Name Dr. Neema Specialty Ortho City Nashville State TX

5. Abilities/Limitations

(a) Patient is: Place remarks in item (b) below, if applicable.

- Capable to undergo checks and direct the use of records thereof? ☒ Yes ☐ No ☐ Other/Describe in (b)
- Able to perform daily activities? ☒ Yes ☐ No ☐ Other/Describe in (b)
- Able to give assistance? ☒ Yes ☐ No ☐ Other/Describe in (b)
- Able to work cooperatively with others in group setting? ☒ Yes ☐ No ☐ Other/Describe in (b)

(b) Selection: Place remarks in item (d) below, if applicable.

- ☐ Heavy work activity: Exceeds 25-50 pounds of force occasionally, and/or 15-25 pounds of force frequently, and/or greater than negligible (5 to 10 pounds) of force constantly.
- ☐ Light work activity: Exerting up to 25 pounds of force occasionally, and/or up to 10 pounds of force frequently, and/or less than negligible (5 to 10 pounds) of force constantly.
- ☐ Sedentary work activity: Exerting a total of less than 10 pounds of force occasionally, and/or a total of less than 5 pounds of force frequently, and/or a total of less than 2 pounds of force constantly.
- ☒ No ability to work: Severe limitation of functional capacity; incapable of performing any work.
- Other: Place remarks in item (d) below.

(c) What medical restrictions/limitations are you placing on patient? (Activities of Daily Living, Driving, Lifting, Pushing, Pulling, and Amounts, etc.) no lifting/pulling/pushing, no prolonged sitting

(d) Number of days patient is capable of working in a way: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23 ☐ 24 ☐ 25 ☐ 26 ☐ 27 ☐ 28 ☐ 29 ☐ 30 ☐ 31 ☐ 32 ☐ 33 ☐ 34 ☐ 35 ☐ 36 ☐ 37 ☐ 38 ☐ 39 ☐ 40 ☐ 41 ☐ 42 ☐ 43 ☐ 44 ☐ 45 ☐ 46 ☐ 47 ☐ 48 ☐ 49 ☐ 50 ☐ 51 ☐ 52 ☐ 53 ☐ 54 ☐ 55 ☐ 56 ☐ 57 ☐ 58 ☐ 59 ☐ 60 ☐ 61 ☐ 62 ☐ 63 ☐ 64 ☐ 65 ☐ 66 ☐ 67 ☐ 68 ☐ 69 ☐ 70 ☐ 71 ☐ 72 ☐ 73 ☐ 74 ☐ 75 ☐ 76 ☐ 77 ☐ 78 ☐ 79 ☐ 80 ☐ 81 ☐ 82 ☐ 83 ☐ 84 ☐ 85 ☐ 86 ☐ 87 ☐ 88 ☐ 89 ☐ 90 ☐ 91 ☐ 92 ☐ 93 ☐ 94 ☐ 95 ☐ 96 ☐ 97 ☐ 98 ☐ 99 ☐ 100 ☐ 101 ☐ 102 ☐ 103 ☐ 104 ☐ 105 ☐ 106 ☐ 107 ☐ 108 ☐ 109 ☐ 110 ☐ 111 ☐ 112 ☐ 113 ☐ 114 ☐ 115 ☐ 116 ☐ 117 ☐ 118 ☐ 119 ☐ 120 ☐ 121 ☐ 122 ☐ 123 ☐ 124 ☐ 125 ☐ 126 ☐ 127 ☐ 128 ☐ 129 ☐ 130 ☐ 131 ☐ 132 ☐ 133 ☐ 134 ☐ 135 ☐ 136 ☐ 137 ☐ 138 ☐ 139 ☐ 140 ☐ 141 ☐ 142 ☐ 143 ☐ 144 ☐ 145 ☐ 146 ☐ 147 ☐ 148 ☐ 149 ☐ 150 ☐ 151 ☐ 152 ☐ 153 ☐ 154 ☐ 155 ☐ 156 ☐ 157 ☐ 158 ☐ 159 ☐ 160 ☐ 161 ☐ 162 ☐ 163 ☐ 164 ☐ 165 ☐ 166 ☐ 167 ☐ 168 ☐ 169 ☐ 170 ☐ 171 ☐ 172 ☐ 173 ☐ 174 ☐ 175 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From: 615 791 0927 Page: 6/7 Date: 6/20/2014 9:55:32 AM

Print Letter

From: AETNA Page: 6/6 Date: 6/16/2014 1:59:33 PM

Page 5 of 5

Any person who knowingly and with intent to injure, defraud or deceive any insured, insured company or other person files an application for insurance or statement of claim containing any material false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act under the law which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of obtaining the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Employee's Signature

Date (MM/DD/YYYY)

WMAE, DC, 5X, 15, 7, 13

Page 2 of 2

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**The Rawlings Company LLC**  
Subrogation Division

Post Office Box 2000  
LaGrange, Kentucky 40031-2000

One Eden Parkway  
LaGrange, Kentucky 40031-8100

Telephone (502) 587-1279

---

## TELECOPY

To:

Our File No: 63140459

Fax Number: 18666671987

From: Adam Wilson

Phone: 502-814-2305

Fax: 502-753-6900

Email acw@rawlingscompany.com

Subject: Workability Claim No.: 9452367

Pages: 2

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**Message:**

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### Confidential Healthcare Information Enclosed

Healthcare information is personal and sensitive information, and you, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Disclosure of this information without additional patient consent or as permitted by law is prohibited. Unauthorized disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately and destroy the related message.





July 21, 2014

Member: ARTHUR DAVIS

SSN: REDACTED

Patient: ARTHUR DAVIS

Date of Loss: 9/27/2013

Our Reference No.: 63140459

Workability Claim No.: 9452367

**Open Disability File**

Please be advised that there is an open subrogation case with The Rawlings Company related to a Motor vehicle accident. The contact person at Rawlings is Adam Wilson and can be reached at 800-928-1279 EXT # 2305.

Currently, the status is pending\_.

For **WKAB** files please fax this completed form to 866-667-1987.

For **ATLS** files please fax this completed form to 866-888-2308.



**PO BOX 19072**  
**GREEN BAY WI 54307-9072**  
**Voice : 866-420-7455 Fax : 920-406-6537**

07/10/2014

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To  
Company AETNA - DISABILITY SERV  
Fax Number 18666671987  
Voice Number 888-382-3862

From Customer Relations  
Fax 920-406-6537  
Voice 866-420-7455  
Subject **InvalidApprovalnotice**  
Order # 33945282

Notes

This fax and any files transmitted with it are confidential and may contain information which is legally privileged or otherwise exempt from disclosure. They are intended solely for the use of the individual or entity to whom this fax is addressed. If you are not one of the named recipients or otherwise have reason to believe that you have received this fax in error, please immediately notify the sender and return or shred these documents immediately. Any other use, retention, dissemination, forwarding, printing, or copying of this email is strictly prohibited

# Invalid Authorization Notice



NOTICE DATE: 07/10/2014

**AETNA - DISABILITY SERV  
PO BOX 14560**

**LEXINGTON, KY 40512-4560**

Patient: **DAVIS, ARTHUR**  
SSN:  
Claim/File #: **9452367**  
Order #: **33945282**  
Fax #: **866-667-1986**

**IMG**

Records requested from: **HERITAGE MEDICAL ASSOCIATES**

**Dear Requester:**

iod incorporated has been retained by the medical facility listed above to handle release of information requests such as yours.

Unfortunately we will not be able to comply with your request due to the following:

**The Authorization to release the records is not valid in accordance with State or Federal law.**

- » Authorization is not HIPAA compliant.
- » Please complete the enclosed Patient Authorization Form and mail or fax it back to us.

If you have any questions regarding this notice, please contact Medical Records Department at 615-284-2222.

*iod incorporated Tax ID No. 65-0765287  
222 22ND STREET SUITE 100 NASHVILLE, TN 37203  
Phone 615-284-2222 \* Fax 615-327-5461*



**Medical Records Release Authorization**

Version 1.3 External

I hereby authorize Heritage Medical Associates to release or disclose to the below-named facility all of my medical records, including any specially protected records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection for the purpose of medical treatment.

**Please "Print" and complete all sections to insure your request is handled in a timely manner**  
**MAIL RECORDS TO:** \_\_\_\_\_

Special Instructions if any: \_\_\_\_\_  
(Specific information requested, etc.) \_\_\_\_\_

**PURPOSE OF DISCLOSURE:** \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Patient's S.S.# \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

**If you Do Not Want certain portions of your medical records released, please read this section carefully and initial the boxes for information you do not want released. Otherwise, your records will be released as specified above.**

\*I hereby authorize (Physician/facility's full name) \_\_\_\_\_ to release the information specified to the organization, agency, or individual named on this request with the exception of:

Initials \_\_\_\_\_ Initials \_\_\_\_\_ Initials \_\_\_\_\_  
\_\_\_\_\_ Substance abuse, if any \_\_\_\_\_ Psychological or psychiatric conditions, if any \_\_\_\_\_ AIDS/HIV/STD's, if any

*This Authorization will expire on the following date or upon the occurrence of the following event: \_\_\_\_\_*

\* I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by Heritage Medical Associates or its physicians, employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to Heritage Medical at the address shown below.

\* I understand that I am not required to sign this Authorization. Heritage Medical Associates will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

\* I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit Heritage Medical Associates' or its physicians', employees' or agents' ability to use or disclose my information for treatment, payment, or health care operations, or as otherwise permitted by law.

**Patient or Authorized Representative's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to the patient:** \_\_\_\_\_

Heritage Medical Associates \* 222 22<sup>nd</sup> Ave. North, Ste 100, Nashville, TN 37203-1870 \* (615) 284-2222

**For an Authorization to be valid, in accordance with State and Federal laws, it must contain all of the following points:**

<b>1.</b>	<b>Identify the Patient.</b> The Patient's name is necessary. The Patient's Date of Birth and/or Social Security Number is optional, but is useful in correctly identifying the Patient.
<b>2.</b>	<b>Be dated.</b>
<b>3.</b>	<b>I include a specific expiration date</b> or event that pertains to the purpose of the disclosure. "24 Months", "One year", "Valid for the duration of the claim", are considered specific. The request for records created after the date of signature on the authorization cannot be released. Please update your authorization to include "records created after date of signature" and have the patient sign it and submit this to us so that we may release the records requested.
<b>4.</b>	<b>Not be expired</b> by the date the request was received. It is permissible to release records beyond the expiration date as long as it was received prior to the expiration date.
<b>5.</b>	<b>Be signed</b> by the patient or the patient's personal representative. The patient's personal representative is a person who is able to authorize medical treatment for the patient or who is acting on behalf of a deceased patient. If the authorization was signed by the Patient's personal representative, then it must provide proof of Legal Guardianship or Power of Attorney and it must provide a description of the patient's personal representative's authority to act for the patient with regard to Healthcare.
<b>6.</b>	<b>Include the name of the provider</b> being asked to disclose the information. It is not OK for the Provider to be identified on the cover letter of the request; it does have to be included in the body of the Authorization form.
<b>7.</b>	<b>Provide the name and address of the Requester</b> to which the information is to be disclosed. It is OK for the Requester name and address to be provided on the cover letter of the request; it does not have to be included in the body of the Authorization form.
<b>8.</b>	<b>Provide a specific and meaningful description of the information to be disclosed.</b> Examples: "ER Report from 5/1/99", "Any and all records" etc.
<b>9.</b>	<b>Give a brief description of the purpose of the disclosure.</b> Examples: "My own personal use", "Legal", "Transferring care", "Insurance benefits" etc. The statement, "at the request of the individual/patient", is sufficient for this purpose.
<b>10.</b>	<b>Specifically cover any State and/or Federally protected information</b> if protected information is contained in the patient's chart.
<b>11.</b>	<b>Include a statement concerning the patient's right to revoke the authorization in writing.</b>
<b>12.</b>	<b>Include a statement regarding the exceptions to the right to revoke an authorization</b> and a description of how to revoke, or a reference to the Notice of Privacy Practices that includes this information.
<b>13.</b>	<b>Include a statement whether the information disclosed might be re-disclosed</b> by the recipient, and therefore, no longer protected..
<b>14.</b>	<b>If the requesting party is a health plan (i.e.: Regence, Molina, Blue Cross, Medicare, etc.) and they are requesting records for a patient who is applying for Health Insurance, then ...</b> include a statement that the Health Care Provider may not condition treatment, payment or eligibility for benefits on whether the patient signs the authorization, or if the Health Care Provider can condition treatment on obtaining authorization, a description of the consequences to the patient for refusing to sign.



# NEUHAUS FOOT & ANKLE

Matthew D. Neuhaus, DPM  
Jason R. Knox, DPM  
Martin L. Toy, DPM  
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3901 Central Pike, Ste 353  
Hermitage, TN 37067  
Phone: (615) 889-2323  
Fax: (615) 889-2370

Lebanon Office  
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To: Shawndra Lee

Fax #: 1-866-667-1987

From: Charles

Today's Date: 7-10-14

# of pages including cover sheet: 7

Re: Arthur Davis

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Aetna Life Insurance Company  
Disability Services - Plantation  
P.O. Box 14560  
Lexington, KY 40512-4560

Shawndra Lee  
LTD Benefit Manager  
954-693-2227  
Fax: 1-866-667-1987

July 9, 2014  
To: Dr. Jason Knox  
Fax: 615-220-8688

RE: ARTHUR DAVIS DOB: **REDACTED** CLAIM #: 9452367

I am the Benefit Manager with Aetna handling Long Term Disability Benefits for the above patient. In order for us to continue Long Term Disability benefits, we need to obtain objective medical data to support the claim.

**Please provide the following information:**

- ☒ Office visit notes from 06/19/2014 to present with Operative Report and/or Procedure Notes (if applicable) and Objective exam findings and diagnostic test results (laboratory tests, x-rays, and MRI tests).
- ☒ Please provide current treatment plan: Patient to follow up  
with his back doctor. No treatment plan by my  
office
- ☒ Last office visit 6-9-14 Next scheduled office visit none

**Return to work plan:**

- ☒ Does your patient currently have work capacity? Yes \_\_\_\_\_ No unknown

Restrictions: I can not give any restrictions to this  
patient. He needs to see his back doctor

Anticipated Full Duty return to work date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: 7-10-14

PLEASE PROVIDE MEDICAL INFORMATION BY: ASAP

❖ Your prompt response is necessary in order to avoid termination of your patient's claim.



## Fax Message

---

**To:** Dr. Jason Knox

**Fax:** 615-220-8688

**From:** Lee, Shawndra E

**Date:** 7/9/2014 10:58 AM

**Pages:** 1 of 2 (including this page)

**Subject:** Re: Arthur Davis REDACTED

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Jul. 10. 2014 9:27AM

No. 8117 P. 4

Patient: Davis, Arthur C (23452)

Male

SSN:

REDACTED

DOB:

REDACTED

50 Yr(s) 9 Month

Address:

REDACTED

Murfreesboro TN 37128

Prof. Lang.: English

Marital Status:

Ethnicity: African Americans

Phone(s): (H)

(W)

(C)

REDACTED

Fax:

Email:

AKA:

Driver's Lic.:

Allergies: chicken derived, peanut, pork derived (porcine)

Diagnosis: (729.5) Pain in Limb, (729.2) Neuritis

#### INSURANCE(S):

Insurance	ID	Group No.	Priority	Start Date	End Date	Copay
-----------	----	-----------	----------	------------	----------	-------

Patient:

1. AETNA W147369146 865237012001C Primary 0.00 / 60.00  
Address: PO BOX 14089, Lexington, KY - 40512

I = Inactive Type: P = Patient Insurance C = Case Insurance

#### CASE(S):

Description	Case Type	Start Date	Injury Date	Provider Name	Hospital
1. General	Illness	6/9/2014		Knox, Jason	

I = Inactive

#### CONTACT(S):

Entity	Name	Phone	Fax
--------	------	-------	-----

Patient:

1. Patient Work Davis, Arthur  
2. Patient Home Davis, Arthur  
3. Patient Cell Davis, Arthur (615) 403-7310  
4. Insurance AETNA (888) 632-3862  
5. Primary Provider Yoneyama, Tadayuki (615) 791-9300 (#1) 615-791-8763  
6. Pharmacy KROGER MIDSOUTH 553 (615) 355-6620 615-355-3083

\* = Current Employer I = Inactive

#### ACCOUNT(S):

Name	From Date	To Date	Phone	Fax
------	-----------	---------	-------	-----

1. Davis, Arthur

#### PRESCRIPTION(S):

Drug	SIG	Provider
------	-----	----------

Pharmacy: KROGER MIDSOUTH 553 Phone: 615-355-6620 Fax: 615-355-3083

ADVAIR 250-50 DISKUS MCG/DOSE

AMLODIPINE BESYLATE 10 MG TAB

BYSTOLIC 10 MG TABLET

CELEBREX 200 MG CAPSULE

OMEPRazole DR 20 MG CAPSULE

ZYRTEC 10 MG LIQUID GELS

**Neuhaus Foot and Ankle**  
300 StoneCrest Blvd Ste 450  
Smyrna TN 371676860  
Phone: 615-220-8788 Fax: 615-220-8688

**Visit Note**

**Provider:** Jason Knox, DPM FACFAS  
**Encounter Date:** Jun 09, 2014

**Patient:** Davis, Arthur C (23452)  
**Sex:** Male **DOB:** REDACTED **Age:** 50 year 8 month  
**Race:** Black/African American  
**Address:** REDACTED Murfreesboro TN 37128  
**Primary Dr.:** Tadayuki Yoneyama, MD  
**Insurance:** AETNA

**HPI:**

This is a 50 year 8 month old patient being seen today for evaluation of. Burning sensation He reports burning sensation. Condition has existed for March 2014. Symptoms were felt gradually. It is located on the plantar surface of the forefoot plantar surface of the midfoot bilaterally. Precipitating events include: car accident in September 2013, burning started after physical therapy in March 2014. Treatment history includes Gabapentin and Lyrica. Severity of condition is worsening. Patient has tried Lyrica, Gabapentin and other medications. The burning is noticed more at night and it affects how patient sleeps. He was diagnosed with herniated disk in lower back in September 2013. He underwent rigorous PT afterward when the burning at feet started.

**Allergy:**

chicken derived, peanut, pork derived (porcine)

**Current Medication:**

- 1 Advair 250-50 Diskus Mcg/dose (Other MD)
- 2 Amlodipine Besylate 10 Mg Tab (Other MD)
- 3 Bystolic 10 Mg Tablet (Other MD)
- 4 Celebrex 200 Mg Capsule (Other MD)
- 5 Omeprazole Dr 20 Mg Capsule (Other MD)
- 6 Zyrtec 10 Mg Liquid Gels (Other MD)

**Past Medical History:**

Shoe Size: 11 arthritis, back problems, Hypertension.

**Past Surgical History:**

shoulder sx knee surgery.

**Patient:** Davis, Arthur C **DOB:** REDACTED **Visit:** 06/09/2014 **Page:** 1

**Social History:**

He denies smoking cigarettes or use of any tobacco products. 1 beer per month He denies recreational drug use. Patient is divorced.

**Family History:**

The patient has a family history of arthritis, Heart Disease and hypertension.

**ROS:**

**Digestive:** (-) constipation, (-) diarrhea, (-) nausea, (-) stomach ulcer.

**Ear/ Nose/ Throat:** (-) hearing loss, (-) ringing ears, (-) sinus congestion, (-) sore throat.

**Endocrine:** (-) excessive thirst, (-) fatigue, (-) frequent urination, (-) hair loss.

**Eyes:** (-) blurry vision, (-) double vision, (-) glasses, (-) poor vision.

**General:** (-) fever, (-) chills, (-) changes in appetite or weight.

**Heart:** (-) chest pain, (-) irregular heartbeat, (-) leg cramps with walking, (-) murmur.

**Hematological:** (-) bleeding tendency, (-) bruise easily, (-) leg swelling, (-) slow to heal.

**Lungs:** (-) cough, (-) difficulty breathing, (-) shortness of breath, (-) snoring.

**Musculoskeletal:** (-) deformity, (-) joint pain, (-) joint stiffness, (-) muscle weakness.

**Neurological:** (+) numbness (+) poor balance (-) sciatica (+) tingling feet.

**Peripheral Vasc.:** (+) Foot pain with sleeping (-) leg cramps (-) leg/ foot swelling (-) varicose veins.

**Psychiatric:** (-) anxiety (-) depression (+) mood swings (-) nervousness.

**Skin:** (-) abnormal scar, (-) dry skin, (-) rash, (-) sores/ulcers.

**Urinary:** (-) burning, (-) frequent urination, (-) impotence, (-) incontinence.

**Vital Signs:**

**Weight:** 240 lbs

**Height:** 6'

**BMI:** 32.55

**BSA:** 2.35

**BP:** 152/94

**Pulse:** 54

**Examination:**

**GENERAL EXAM:** Patient is overweight, showing good hygiene and body habitus and alert and communicates well.

**CARDIOVASCULAR:** Both Dorsalis Pedis pulses are palpable. Both Posterior Tibial pulses are palpable. Capillary refill is less than 3 seconds in both feet. No generalized edema noted.

**NEUROLOGIC:** Gross sensation intact on both. Sensation to Semmes Weinstein 5.07/ 10 g monofilament is intact over both feet. Vibratory sense is normal over both feet. Negative Clonus Sign both feet. Negative Babinski Reflex both feet. Negative Tinel's and Valleix's Sign with percussion of Tibial nerve at tarsal tunnel, percussion of the sural and superficial peroneal nerves.

**DERMATOLOGIC:** Bilateral exam shows no open lesions, rashes nor areas of hyperkeratotic tissue. Good skin texture and turgor. No focalized erythema or edema. Webspaces inspected and

Patient: Davis, Arthur C DOB: **REDACTED** Visit: 06/09/2014 Page: 2

no pathology found.

MUSCULOSKELETAL: No limitation or pain in general range of motion of any foot or ankle joint bilateral. Muscle strength is normal and strong in all directions. Bony prominences are unremarkable.

BIOMECHANICS: No gross biomechanical abnormalities.

**Diagnosis:**

729.2 Neuritis

729.5 Pain in Limb

**Plan:**

PATIENT EDUCATION:

DISCUSSION: The patient's complaints and exam findings were talked about in detail.

Etiologies and treatments were also discussed. Conservative and Surgical treatment options were discussed in detail.

TIME SPENT: 30 min spent with patient in face to face discussion.

I suspect that during "boot camp" rigorous Physical Therapy that the herniated disk was made worse and this is the cause of the feet pain. The other most likely causes of burning have been ruled out. I have asked patient to talk with his back doctor this week about seeing a back surgeon.

RETURN VISIT: Patient is instructed to return as needed if problem returns or if a new problem develops.

This visit note has been electronically signed off by Jason Knox, DPM FACFAS.

Patient: Davis, Arthur C DOB: REDACTED Visit: 06/09/2014 Page: 3

**aetna**<sup>SM</sup>

## Fax Message

482122  
58

**To:** Dr. Breena Green

**Fax:** 615-867-7974

**From:** Lee, Shawndra E

**Date:** 7/9/2014 10:57 AM

**Pages:** 1 of 2 (including this page)

**Subject:** RE: Arthur Davis **REDACTED**

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**Aetna Life Insurance Company  
Disability Services - Plantation  
P.O. Box 14560  
Lexington, KY 40512-4560**

**Shawndra Lee**  
**LTD Benefit Manager**  
**954-693-2227**  
**Fax: 1-866-667-1987**

July 9, 2014  
To: Dr. Breena Green  
Fax: 615-867-7974

RE: ARTHUR DAVIS DOB: REDACTED CLAIM #: 9452367

**I am the Benefit Manager with Aetna handling Long Term Disability Benefits for the above patient. In order for us to continue Long Term Disability benefits, we need to obtain objective medical data to support the claim.**

**Please provide the following information:**

- ☒ Office visit notes from 06/19/2014 to present with Operative Report and/or Procedure Notes (if applicable) and Objective exam findings and diagnostic test results (laboratory tests, x-rays, and MRI tests).

- ☒ Please provide current treatment plan: HEP, weight management, pain medication

- ☒ Last office visit 6/19/14 Next scheduled office visit 7/31/14

**Return to work plan:**

- ☒ Does your patient currently have work capacity? Yes \_\_\_\_\_ No \_\_\_\_\_  
He needs a functional capacity evaluation  
to evaluate his abilities/restrictions.

Restrictions:

Anticipated Full Duty return to work date: TBD.

Physician Signature: [Signature] Date: 7/9/14

**PLEASE PROVIDE MEDICAL INFORMATION BY: ASAP**

❖ **Your prompt response is necessary in order to avoid termination of your patient's claim.**



## Fax Message

---

**To:** BES  
**Fax:** 866-667-1987  
**From:** Lee, Shawndra E  
**Date:** 7/9/2014 10:58 AM  
**Pages:** 1 of 2 (including this page)  
**Subject:** Re: Arthur Davis 10/03/1963

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Aetna Life Insurance Company  
Disability Services - Plantation  
P.O. Box 14560  
Lexington, KY 40512-4560

Shawndra Lee  
LTD Benefit Manager  
954-693-2227  
Fax: 1-866-667-1987

July 9, 2014  
To: Dr. Jason Knox  
Fax: 615-220-8688

RE: ARTHUR DAVIS DOB: [REDACTED] CLAIM #: 9452367

I am the Benefit Manager with Aetna handling Long Term Disability Benefits for the above patient. In order for us to continue Long Term Disability benefits, we need to obtain objective medical data to support the claim.

**Please provide the following information:**

☒ Office visit notes from 06/19/2014 to present with Operative Report and/or Procedure Notes (if applicable) and Objective exam findings and diagnostic test results (laboratory tests, x-rays, and MRI tests).

☒ Please provide current treatment plan: \_\_\_\_\_  
\_\_\_\_\_

☒ Last office visit \_\_\_\_\_ Next scheduled office visit \_\_\_\_\_

**Return to work plan:**

☒ Does your patient currently have work capacity? Yes \_\_\_\_\_ No \_\_\_\_\_

Restrictions: \_\_\_\_\_  
\_\_\_\_\_

Anticipated Full Duty return to work date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE PROVIDE MEDICAL INFORMATION BY: ASAP

❖ Your prompt response is necessary in order to avoid termination of your patient's claim.





# Fax Message

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**To:** BES  
**Fax:** 866-667-1987  
**From:** Lee, Shawndra E  
**Date:** 7/9/2014 10:57 AM  
**Pages:** 1 of 2 (including this page)  
**Subject:** RE: Arthur Davis 10/03/1963

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Aetna Life Insurance Company  
Disability Services - Plantation  
P.O. Box 14560  
Lexington, KY 40512-4560

Shawndra Lee  
LTD Benefit Manager  
954-693-2227  
Fax: 1-866-667-1987

July 9, 2014  
To: Dr. Breena Green  
Fax: 615-867-7974

RE: ARTHUR DAVIS DOB: REDACTED CLAIM #: 9452367

I am the Benefit Manager with Aetna handling Long Term Disability Benefits for the above patient. In order for us to continue Long Term Disability benefits, we need to obtain objective medical data to support the claim.

**Please provide the following information:**

☒ Office visit notes from 06/19/2014 to present with Operative Report and/or Procedure Notes (if applicable) and Objective exam findings and diagnostic test results (laboratory tests, x-rays, and MRI tests).

☒ Please provide current treatment plan: \_\_\_\_\_  
\_\_\_\_\_

☒ Last office visit \_\_\_\_\_ Next scheduled office visit \_\_\_\_\_

**Return to work plan:**

☒ Does your patient currently have work capacity? Yes \_\_\_\_\_ No \_\_\_\_\_

Restrictions: \_\_\_\_\_  
\_\_\_\_\_

Anticipated Full Duty return to work date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE PROVIDE MEDICAL INFORMATION BY: ASAP

❖ Your prompt response is necessary in order to avoid termination of your patient's claim.



## Fax Message

---

**To:** BES  
**Fax:** 866-667-1987  
**From:** Lee, Shawndra E  
**Date:** 7/9/2014 11:01 AM  
**Pages:** 1 of 2 (including this page)  
**Subject:** Re: Arthur Davis 10/03/1963

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Aetna Life Insurance Company  
Disability Services - Plantation  
P.O. Box 14560  
Lexington, KY 40512-4560

Shawndra Lee  
LTD Benefit Manager  
954-693-2227  
Fax: 1-866-667-1987

July 9, 2014  
To: Dr. Subir Prasad  
Fax: 615-916-3953

RE: ARTHUR DAVIS DOB: REDACTED CLAIM #: 9452367

I am the Benefit Manager with Aetna handling Long Term Disability Benefits for the above patient. In order for us to continue Long Term Disability benefits, we need to obtain objective medical data to support the claim.

**Please provide the following information:**

☒ Office visit notes from 05/29/2014 to present with Operative Report and/or Procedure Notes (if applicable) and Objective exam findings and diagnostic test results (laboratory tests, x-rays, and MRI tests).

☒ Please provide current treatment plan: \_\_\_\_\_  
\_\_\_\_\_

☒ Last office visit \_\_\_\_\_ Next scheduled office visit \_\_\_\_\_

**Return to work plan:**

☒ Does your patient currently have work capacity? Yes \_\_\_\_\_ No \_\_\_\_\_

Restrictions: \_\_\_\_\_  
\_\_\_\_\_

Anticipated Full Duty return to work date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE PROVIDE MEDICAL INFORMATION BY: ASAP

❖ Your prompt response is necessary in order to avoid termination of your patient's claim.

From: AETNA Page: 1/7 Date: 6/23/2014 9:55:31 AM



## Fax Message

---

**To:** Dr. SUBIR PRASAD

**Fax:** 615-916-3953

**From:** Peterson, Jacob O

**Date:** 6/23/2014 10:52 AM

**Pages:** 1 of 7 (including this page)

**Subject:**

---

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Print Letter

From: AETNA Page: 2/7 Date: 6/23/2014 9:55:32 AM

Page 1 of 1

**aetna** PO Box 14560  
Lexington, KY 40512-4560  
800-354-1779

LEE

## Facsimile Transmittal Sheet

To:	From:
Dr. SUBIR PRASAD	Aetna Disability
Employer:	Date:
Dell Inc.	06/23/2014
Fax Number: 615-916-3953	CLAIM NUMBER:
	9452367
Phone number:	Sender's Phone Number:
	800-354-1779
	Sender's FAX Number:
	1-866-667-1987
Re: MR. ARTHUR DAVIS	Total No. of Pages Including Cover:
Date of Birth: REDACTED	6

Urgent For Review Please Comment Please Reply Please Recycle

Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

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## Enclosed:

Attending Physician Statement  
Capabilities and Limitations Worksheet

This fax was received by GFI FAXmaker fax server. For more information, visit: <http://www.gfi.com>

Print Letter

From: AETNA Page: 3/7 Date: 6/23/2014 9:55:32 AM

Page 2 of

Claim Number: 9452367

**aetna****Attending Physician Statement**

Aetna Life Insurance Company  
 PO Box 14560  
 Lexington, KY 40512-4560  
 Phone: 800-354-1779  
 Fax: 1-866-667-1987

**1. Patient Information**

Name	Arthur Davis			Employer Name	Job Title
Year of Birth	REDACTED	Gender	<input type="checkbox"/> F <input checked="" type="checkbox"/> M	Smoker	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		Height (ft./in.)	Weight (lbs.)	BMI	Blood Pressure
		6'0"	249		144/96
					Date Measured
					5/29/14

**2. Diagnostic Information**

Primary Diagnosis	Paresthesia	
ICD-9 Code(s)	782.0	DSM IV Code(s)
Complications		
Objective Findings	See claim note	
Subjective Symptoms	See claim note	
Are there any secondary conditions contributing to this condition?		
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, what are they?		
Has this patient ever had the same condition or a similar condition?		
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, what year(s)/describe? Not evaluated by me		

**3. Treatment Information**

Primary Diagnosis	Paresthesia	First day recommended out of work
Date symptoms first appeared (or date of accident)	Date first treated for this condition	Most recent date treated for this condition
September 2013	5/29/14	5/29/14
Frequency with which you see this patient:	Provide date(s)	ICD9 code(s)
<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input checked="" type="checkbox"/> Other	once 5/29/14	
Has the patient undergone surgery?	CPT code(s) & Procedure	Result
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Do you expect surgery to be performed in the future?	If Yes, provide date.	Planned Procedure & CPT code
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Please list current medications with dosage and frequency.		
Dexam 2mg QHS		
Please list other types and frequency of treatment.		
Is the patient a suitable candidate for vocational rehabilitation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Please explain.		

**4. Please list all treating or consulting physicians (include date of treatment as indicated).**

a. Physician Name	Physician Telephone Number
Physician Address	Treatment Dates
	From: / /
	To: / /
b. Physician Name	Physician Telephone Number
Physician Address	Treatment Dates
	From: / /
	To: / /
c. Physician Name	Physician Telephone Number
Physician Full Address	Treatment Dates
	From: / /
	To: / /

WVAB  
 GR-68337 (7-13)

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Print Letter

From: AETNA Page: 4/7 Date: 6/23/2014 9:55:33 AM

Page 3 of

Claim Number: 9452367

Patient Name <b>Arthur Davis</b>	Year of Birth <b>REDACTED</b>
-------------------------------------	----------------------------------

Page 2

5. Please indicate any hospital / medical rehabilitation confinement for this patient, for this condition (include dates of confinement as indicated).

a. Hospital / Facility Name <b>none</b>	
Hospital / Facility Full Address	Treatment Dates From: <b>1</b> / <b>1</b> / <b>1</b> To: <b>1</b> / <b>1</b> / <b>1</b>
b. Hospital / Facility Name	
Hospital / Facility Full Address	Treatment Dates From: <b>1</b> / <b>1</b> / <b>1</b> To: <b>1</b> / <b>1</b> / <b>1</b>

## 6. Progress

Patient Status	
<input type="checkbox"/> Recovered	<input type="checkbox"/> Improved
<input checked="" type="checkbox"/> Ambulatory	<input type="checkbox"/> Home Bound
<input type="checkbox"/> Unchanged	<input type="checkbox"/> Bed Confined
<input type="checkbox"/> Retrogressed	<input type="checkbox"/> Hospitalized
What is the prognosis? <b>good</b>	
Has the patient achieved Maximum Medical Improvement? <b>yes</b> How soon do you expect fundamental changes in the patient's medical condition? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>uncertain - not seen again</b> <input type="checkbox"/> 1-2 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 3-4 months <input type="checkbox"/> More than 6 months	
Please note any restrictions (activities your patient should not do). <b>none by me</b>	
Please note any limitations (activities your patient cannot). <b>none by me</b>	
Please describe any physical and/or MENTAL impairments.	
Date patient released from your care (if applicable). <b>5/22/14</b>	Date patient able to return to full duty. <b>never restricted by me - ask Dr. doctors</b>

## 7. Level of Impairment

Physical Impairment (if applicable):	
<input checked="" type="checkbox"/> Class 1. No limitation of functional capacity/capable of heavy work.	
<input type="checkbox"/> Class 2. Slight limitation of functional capacity/capable of medium manual work.	
<input type="checkbox"/> Class 3. Moderate limitation of functional capacity/capable of light work.	
<input type="checkbox"/> Class 4. Marked limitation of functional capacity/capable of sedentary work.	
<input type="checkbox"/> Class 5. Severe limitation of functional capacity/incapable of sedentary work.	
Mental/Nervous Impairment (if applicable):	
<input checked="" type="checkbox"/> No Limitation: able to function under stress and engage in interpersonal relationships.	
<input type="checkbox"/> Slight limitation: able to function in most stress situations and engage in most interpersonal relationships.	
<input type="checkbox"/> Moderate limitation: able to engage in only limited stress and limited interpersonal relationships.	
<input type="checkbox"/> Marked limitation: unable to engage in stress or interpersonal relationships.	
<input type="checkbox"/> Severe limitation: has significant loss of psychological, physiological, personal and social adjustment.	
Cardiac Functional Capacity - NY Heart Association:	
<input type="checkbox"/> Class 1. No limitation <input type="checkbox"/> Class 2. Slight limitation <input type="checkbox"/> Class 3. Moderate limitation <input type="checkbox"/> Class 4. Complete limitation	
Do you believe your patient is competent to endorse checks and direct the use of the proceeds thereof? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Comments/Information	

## 8. Attending Physician Information

Physician's Signature <b>[Signature]</b>		Date (MM/DD/YYYY) <b>6/12/14</b>
Physician Name: <b>Subir Prasad</b>	Specialty: <b>Neurology</b>	
Phone Number: <b>(615) 425-1605</b>	Fax Number: <b>(615) 916-3953</b>	
Address: <b>4430 Harding Rd 805E Nashville, TN 37205</b>		

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.

WKAB-GR-88337 (7-13)



PATIENT NAME

TOTAL AMOUNT

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From: AETNA Page: 6/7 Date: 6/23/2014 9:55:33 AM

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**9. Misrepresentation**

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

WKAB  
GR-88337 (7-13)

Page 2



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Claim Number: 9452367

**aetna** Capabilities and Limitations Worksheet

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company  
 PO Box 14560  
 Lexington, KY 40512-4560  
 Phone: 800-354-1779  
 Fax: 1-866-667-1987

Employee Name (Last, First, Middle Initial) <b>DAVIS, ARTHUR</b>		Social Security Number	Year of Birth
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Job Title	Control Number <b>0476626</b>	
Current Diagnosis <b>Parosphoria</b>		Medications:	
Indicate the percent of the day the following activities can be performed: <input checked="" type="checkbox"/> Occasional 1-33% or .5-2.5 hrs. <input type="checkbox"/> Frequent 34-66% or 2.6-5.0 hrs. <input type="checkbox"/> Continuous 67-100% or 5.1-8 hrs. or <input type="checkbox"/> Never			
Climbing - <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Crawling <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Kneeling <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Lifting <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Pulling <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Pushing <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Reaching above shoulder <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Forward reaching <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Carrying <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Bending <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Twisting <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N	Hand Grasping <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Firm Hand Grasping <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Fine Manipulation <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Gross Manipulation <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Repetitive Motion <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Sitting <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Standing <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Stooping <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Walking <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N Other _____		
Maximum weight patient is capable of lifting: 1 - 5 lbs. <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N 6 - 10 lbs. <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N 11 - 20 lbs. <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N 21 - 35 lbs. <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N 36 - 50 lbs. <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N 51 - 75 lbs. <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N 76 - 100 lbs. <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N 100 lbs. + <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> N	Approved Head and Neck Movements: Static Position <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Flexing <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Rotation <input type="checkbox"/> Yes <input type="checkbox"/> No Can the Patient operate: A Motor Vehicle <input type="checkbox"/> Yes <input type="checkbox"/> No Hazardous Machine <input type="checkbox"/> Yes <input type="checkbox"/> No Power Tools <input type="checkbox"/> Yes <input type="checkbox"/> No		
Limitations to: Speaking _____ hrs Vision (explain) _____ Depth Perception _____ Hearing (explain) _____	Exposure Limitations: Yes No Heat <input type="checkbox"/> <input type="checkbox"/> Dust <input type="checkbox"/> <input type="checkbox"/> Cold <input type="checkbox"/> <input type="checkbox"/> Fumes <input type="checkbox"/> <input type="checkbox"/> Dampness <input type="checkbox"/> <input type="checkbox"/> Chemicals <input type="checkbox"/> <input type="checkbox"/> Noise <input type="checkbox"/> <input type="checkbox"/> Radiation <input type="checkbox"/> <input type="checkbox"/>		
Total # of hours patient capable of working per day: 12 <input type="checkbox"/> 8 <input type="checkbox"/> 6 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> Duration of restrictions: _____ Care Complete: Yes <input type="checkbox"/> No <input type="checkbox"/> Next Appointment: _____ Additional Comments: _____			
Physician's Signature <i>Subir Prasad</i>		Date (MM/DD/YYYY) <b>06/25/2014</b>	
Physician Name <b>Subir Prasad</b>		Specialty <b>Neurology</b>	
Phone Number <b>(615) 425-7605</b>		Fax Number <b>(615) 916-3953</b>	
Address <b>4230 Harding Rd, 805E. Nashville, TN 37205</b>			

As +  
 tested  
 or  
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 by wa

WKAB  
 GC-1500-26 (7-13)

Page 1 of 2

Claim Number: 9452367

Employee Name (Last, First, Middle Initial) Required  
**DAVIS, ARTHUR**

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**Misrepresentation**

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Employee's Signature

Date (MM/DD/YYYY)

WKAB-GC-1500-26 (7-13)

Page 2 of 2



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WVAB  
60-102-26 (7-13) C

Page 3



Claim Number: 9452367

**aetna** Capabilities and Limitations  
Worksheet

Complete and sign the form using BLUE or BLACK ink.

 Aetna Life Insurance Company  
 PO Box 14560  
 Lexington, KY 40512-4560  
 Phone: 800-354-1779  
 Fax: 1-866-667-1987

Employee Name (Last, First, Middle Initial) <b>DAVIS, ARTHUR</b>		Social Security Number		Year of Birth	
Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		Job Title		Control Number <b>0476626</b>	
Current Diagnosis <b>Shoulder pain LBP Pain in back</b>		Medical obs. <b>See list</b>			
Indicate the percent of the day the following activities can be performed: <input type="checkbox"/> Occasional 1-33% or 5-25 hrs <input type="checkbox"/> Frequent 34-65% or 2.5-5.0 hrs <input type="checkbox"/> Continuous 67-100% or 5.1-8 hrs. or <input type="checkbox"/> Never					
Climbing	<input type="checkbox"/>	Hand Grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	Firm Hand Grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	Fine Manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	Gross Manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing	<input type="checkbox"/>	Repetitive Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching above shoulder	<input type="checkbox"/>	Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching forward	<input type="checkbox"/>	Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying	<input type="checkbox"/>	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maximum weight patient is capable of lifting <input type="checkbox"/> 1-5 lbs <input type="checkbox"/> 6-10 lbs <input type="checkbox"/> 11-20 lbs <input type="checkbox"/> 21-35 lbs <input type="checkbox"/> 36-50 lbs <input type="checkbox"/> 51-75 lbs <input type="checkbox"/> 76-100 lbs <input type="checkbox"/> 101 lbs +		Approved Head and Neck Movements: Side Flexion <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Flexion <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Rotation <input type="checkbox"/> Yes <input type="checkbox"/> No			
		Can the Patient operate: <input type="checkbox"/> A Motor Vehicle <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Hazardous Machine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Power Tools <input type="checkbox"/> Yes <input type="checkbox"/> No			
Limitations to: Speaking <input type="checkbox"/> Yes <input type="checkbox"/> No Vision (explain) _____ Depth Perception _____ Hearing (explain) _____		Exposure Limitations: Yes <input type="checkbox"/> No <input type="checkbox"/> Heat <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cold <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Dampness <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Noise <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Dust <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Fumes <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Chemicals <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Radiation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			
Total # of hours patient capable of working per day 12 <input type="checkbox"/> 8 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/>		Care Complete Yes <input type="checkbox"/> No <input type="checkbox"/> Next Appointment _____			
Additional Comments _____					
Physician's Signature _____		Date (MM/DD/YYYY) _____			
Physician Name _____		Specialty _____			
Phone Number _____		Fax Number _____			
Address _____					

please  
ask  
on the  
for  
evaluation

WJ Yaregan  
6-20-2014

WVAB  
60-102-26 (7-13) C

Page 1 of 2


 Employee Name (Last, First, Middle Initial) Required  
 DAVIS, ARTHUR

Misrepresentation

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From: AETNA Page: 6/6 Date: 6/16/2014 1:59:33 PM

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Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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Employee's Signature

Date (MM/DD/YYYY)

WKAB-GC-1500-26 (7-13)

Page 2 of 2



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To: Dell Incq= Subject: Forms

Fax: 866-667-1987 Date: 6-20-14

From: Dr.Tad Yoneyama- Jana Pages: 8

Fax: 615-916-3903 Phone 615-224-1975

Message

Fax. (615)	Fax. (615)	Fax. (615)	Fax. (615)
503-2953 Alberico, Dr. Tammy	916-3904 Gandhi, Dr. Amy	916-3925 Meyer, Dr. Richard	953-4091 Stirling, Kristen
916-3926 Anderson, Dr. Edwin	503-2953 Gish, Jonathan	916-3923 Mire, Dr. Ryan	916-3889 Storck, Dr. Kristina
564-2974 Austin-White, Martha	297-2593 Grinder, Shalene	953-4092 Moody, Dr. Brent	916-3890 Strnad, Dr. Allison
916-3954 Baggott, Dr. Nicole	369-1321 Gupta, Dr. Sonal	791-8219 Mowery, Dr. Greg	916-3896 Stubblefield, Dr. Mark
503-2948 Bailes, Dr. Elizabeth	916-3876 Hagenau, Dr. Curt	297-1835 Mukundan, Dr. Chetan	916-3865 Tai, Dr. Steven
916-3946 Bastian, Dr. Sam	916-3859 Harrell, Dr. Henry	916-3854 Olive, Dr. Michael	916-3978 Tatalovich, Dr. Jennifer
791-9206 Bergeron, Dr. Kim	284-2598 Hawkins, Dr. Roland	916-3962 Ozan, Dr. Aydin	771-7229 Thomas, Dr. J.T.
916-3921 Bonvissuto, Dr. Linda	794-8737 Hendrix, Dr. Julie	916-3868 Parker, Dr. Joe	916-3927 Thompson, Dr. John
916-3855 Booker, Dr. Tammy	916-3905 Howard, Laura	916-3929 Parker, Dr. Morgan	503-2962 Trump, Iveylee
284-2492 Brothers, Dr. Don	791-8219 Huber, Dr. Todd	916-3866 Patten, Dr. Thomas	791-9206 Walling, Leigh
916-3891 Brown, Dr. Doug	916-3953 Humphrey, Tereza	916-3916 Payne, Dr. Rose	297-2593 Waterhouse, Dr. Heather
916-3864 Bryant, Dr. David	916-3961 Humphrey-Johnson, Dr.	369-1321 Pharris, Dr. Larry	324-1219 Wierum, Dr. Craig
564-2974 Burt, Dr. Jerome	564-2974 Jacobs, Dr. Jake	916-3953 Prasad, Dr. Subir	916-3856 Wile, Dr. Laura
916-3886 Byrd, Dr. Victor	376-6044 Janjic, Traci	916-3878 Rand, Dr. Heidi	916-3871 Wright, Dr. George
916-3902 Calisi, Dr. Cindy	916-3915 Jones, Dr. James	297-1835 Rauth, Dr. Lindsay	376-6044 Wright, Dr. Sharon
916-3863 Callaway, Dr. Mike	284-2598 Kerr, Dr. Mary Frances	916-3862 Ray, Dr. Clark	916-3971 Wright, Tiffany
916-3857 Callaway, Dr. Tom	297-1835 Klinsky, Dr. Lawrence	916-3887 Rhea, Dr. Christian	916-3903 Yoneyama, Dr. Tad
376-6044 Caprio, Dr. Francis	916-3860 Ledford, Dr. Robert	916-3870 Roberts, Dr. Ryan	916-3943 Zak, Dr. Beverly
916-3971 Carlton, Anna	916-3879 Lee, Dr. Carla	916-3952 Rossell, Dr. Anne	916-3928 Zanolli, Dr. Michael
916-3944 Carman, Dr. Jennifer	916-3861 Lewis, Dr. Rodney	916-3924 Ryan, Dr. Sean	HMA DEPARTMENTS
916-3914 Cato, Dr. James	916-3894 Lipsitz, Dr. Nancy	916-3976 Sanders, Dr. Margaret	284-2875 Administration
916-3892 Cox, Dr. Joy	916-3947 Lyons, Dr. Elizabeth	916-3852 Scudder, Dr. Donna	564-2980 Accounts Payable
916-3922 Cromwell, Dr. Brian	297-1835 Mallard, Dr. Robert	503-2948 Seethaler, Dr. Neil	284-3984 Billing
916-3858 Crowder, Dr. Robert	771-7229 Martin, Dr. Craig	503-2957 Shaw, Dr. Amy	284-2257 Diagnostic Imaging
503-2948 Dykstra, Dr. Elizabeth	916-3853 Martin, Dr. Karen	916-3869 Shull, Dr. Harrison	916-3872 Endoscopy Lab
916-3895 Emfinger, Dr. Wesley	916-3959 McGinley, Dr. Daniel	916-3849 Smith, Dr. Allison	327-7933 Human Resources
916-3884 Fentriss, Dr. Lee	916-3898 McGinley, Dr. James	284-2492 Smith, Dr. Keegan	284-2493 Laboratory
916-3893 Fournace, Lisa	916-3867 McMillen, Dr. David	297-1835 Smith, Dr. Paige	327-5461 Medical Records
916-3918 Franklin, Dr. Leslie	771-7229 Meadors, Dr. Bernadette	916-3917 Smithson, Dr. Joshua	284-2248 PBX and Scanning
503-2962 Franklin, Dr. Shelley	916-3964 Meadors, Dr. Porter	324-1219 Snow, Dr. Rodney	284-2253 Purchasing

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From: AETNA Page: 1/6 Date: 6/16/2014 1:59:31 PM

**aetna**<sup>SM</sup>

## Fax Message

**To:** Yoncyama Heritage Medical**Fax:** 6159163903**From:** Greene Celestine, Wanda**Date:** 6/16/2014 2:55 PM**Pages:** 1 of 6 (including this page)**Subject:** Arthur Davis**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

*please print  
med list to go with forms  
call pt to pick up  
\$25 form fee  
ry*

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Print Letter

From: AETNA

Page: 2/6

Date: 6/16/2014 1:59:31 PM

Page 1 of 5

**aetna®**

06/16/2014

Dr. Tad Yoneyama Heritage Medical  
2338 Hillsboro Road  
Franklin TN - 37069

Group Control No: 0476626  
Employer: Dell Inc.  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

To Whom It May Concern:

The Dell Inc. group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna). To properly evaluate their eligibility for continued disability benefits, information is needed from your office.

Please include current office and/or chart notes, along with any medical documentation you may have including, labs, blood work, physical exam, MR/X-ray, and the results of any other diagnostic test from the last office visit. We also ask that you complete the attached Attending Physician Statement and Capabilities and Limitations Work Sheet.

Dell Inc.'s Program requires a clinical review of the medical appropriateness for your patient's work absence. Your office can fax the documents to 1-866-667-1987 or mail them to:

Aetna Life Insurance Company  
Dell Inc. LTD Program  
PO Box 14560  
Lexington, KY 40512-4560

It is important to understand that if we do not receive the requested documentation by July 1, 2014 your patient's case may be closed and benefits may be terminated.

Should you have any questions regarding your claim, please call 800-354-1779 and an Aetna Customer Service Representative will be happy to assist you.

Sincerely,

Wanda Greene Celestine  
Senior Technical Specialist  
Aetna Life Insurance Company

Enclosures  
Attending Physician Statement  
Capabilities and Limitations Worksheet

PO Box 14560  
Lexington, KY 40512-4560  
SHAWNDRA LEE  
STD BENEFIT MANAGER  
Phone: 800-354-1779  
Fax: 1-866-667-1987

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Print Letter

From: AETNA Page: 3/6 Date: 6/16/2014 1:59:31 PM

Page 2 of 5

Claim Number: 0452367

**aetna****Attending Physician Statement**  
Complete and sign the form using BLUE or BLACK ink.Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: 800-354-1779  
Fax: 1-866-667-1987

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title I from requesting or requiring genetic information of an individual or family member of the individual, except as expressly allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assisted reproductive services. Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.

1. Patient Instructions — The Physician will complete Sections 2 through 7.  
The Patient will complete Sections 1 and 6.  
The Patient should also fill in their name at the top of Pages 2 and 3.

The Patient is responsible for completing this section, and for ensuring that their Attending Physician completes the remainder of this statement. The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. If you have any questions, please call 800-354-1779.

(a) Control Number: 0476626 REDACTED

(b) Patient Name (Last, First, Middle Initial): DAVIS, ARTHUR REDACTED

(c) Patient Gender: ☒ Male ☐ Female

(d) Patient Home Address — Resides (Current Ho., Street, Town, State, ZIP — no PO boxes) ☐ Check if New

(e) Mailing Address, if different from Home Address

(f) Patient Employer Name/City/State: Call Inc.

(g) Patient Telephone Number ☐ Check if New

(h) Job Title/Occupation: Inside Sales Account Mgmt. II

(i) Type of Claim: ☐ Short Term Disability ☐ Long Term Disability ☐ Worker's Compensation ☐ Long Term / Permanent Total Disability

## 2. Physician Instructions

The Attending Physician should complete the items below, based upon a recent examination. Attach additional documentation as needed. If you have any questions, please call 800-354-1779.  
Please complete form in its entirety and fax to 1-866-667-1987. Pages 2 and 3 MUST be completed before faxing.

## 3. Impairing Diagnosis &amp; Treatment

(a) For medical reasons, the patient will need to be absent from work due to a disability beginning on 10/2/2013 and ending on unknown

(b) Primary Diagnosis: Shoulder Pain Primary ICD Code: 719.41

Secondary Diagnosis: LBP Secondary ICD Code: 720.5

Other Diagnosis: Carpal Tunnel Syndrome Other ICD Code: 730.2

(c) Height: 72" Weight: 247 lbs Date Measured (MM/DD/YYYY): 5-23-2014

(d) If Pregnantly related, delivery or expected due date: N/A Month: Day: Year:

(e) Delivery Type: ☐ Vaginal ☐ Cesarean

(f) Surgery Date: Month: Day: Year:

(g) Primary Procedure: Primary CPT Code:

Secondary Procedure: Secondary CPT Code:

Other Procedures: Other CPT Codes:

(h) Medication(s)/Dose/Frequency: see list

(i) Impairment from medication effects: sedation

(j) Is patient still under your care for this condition? ☒ Yes ☐ No Date service terminated:

(k) Treatment Summary: med management refer to aetna / ortho

(l) Office Visit Dates: First: 9-19-2013 Last: 5-23-2014 Frequency of appointments: 03 months

(m) Was patient recently hospitalized? ☐ No ☒ Yes Date hospitalized: Admit: Discharge:

(n) Hospital Name/City/State: please contact Dr Penfro

① Shoulder 10/2/2013

② Shoulder 1-31-2014

③ Knee 4-23-2014

last surgery 4-23-2014

WKAB-30-118628 (7-13) P. 8-2003

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From: AETNA Page: 4/6 Date: 6/16/2014 1:59:32 PM

Print Letter

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Claim Number: 9452367

Page 2

Patient Name (Last, First, Middle Initial) Required  
DAVIS, ARTHUR

## 4. History

(a) Symptoms: shoulder pain, back pain, knee pain  
foot pain

(b) Date symptoms first appeared or accident happened: Month 8 Day 2 Year 2013

(c) Has patient ever had same or similar condition? ☒ No ☐ Yes State when and describe.

(d) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☒ Unknown

(e) Other Treating Physicians:  
 Name Dr. Prasad Neema Specialty ortho City Franklin State TN  
 Name Dr. Renfro Specialty ortho City Nashville State TN

## 5. Abilities/Limitations

(a) Patient is: Place remarks in item (d) below, if applicable.

- Competent to analyze checks and direct the use of proceeds thereof? ☒ Yes ☐ No ☐ Other/describe in (c)
- Able to work with others? ☒ Yes ☐ No ☐ Other/describe in (c)
- Able to give supervision? ☒ Yes ☐ No ☐ Other/describe in (c)
- Able to work cooperatively with others in group setting? ☒ Yes ☐ No ☐ Other/describe in (c)
- Able to do? Select one: Place remarks in item (d) below, if applicable.
  - ☐ Heavy work activity: No limitation of functional capacity.
  - ☐ Medium work activity: Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than that up to 10 pounds of force constantly.
  - ☐ Light work activity: Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently.
  - ☐ Sedentary work activity: Moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. (Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.)
  - ☒ No ability to work: Severe limitation of functional capacity, incapable of minimal activity.

(b) What medical restrictions/limitations are you placing on patient? (Activities of Daily Living, Driving, Lifting, Putting, Pushing, and Amounts, etc.) No lift/pull/push, no prolonged sitting

- Number of hours patient is capable of working in a day: ☐ 12 ☐ 10 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐ 1 Hour/Day
- Number of days per week patient is able to work: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week
- Date you prescribed restriction on work activities: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- How long are these restrictions/limitations in effect? Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ ☐ No Longer
- Estimated return to work date? (MM/DD/YYYY) Modified Duty (MM/DD/YYYY) Full Duty

(c) Objective findings that substantiate impairment (consult laboratory, physical and/or mental status examination and other testing)

(d) Other Comments

## 6. Current Status

(a) Patient has: ☒ Improved ☐ Stabilized ☐ Regressed ☐ Not Applicable

(b) Is there a medical contraindication for patient to participate in Vocational Rehabilitation/Job training programs?  
☐ No ☒ Yes please explain: cannot sit for prolonged time

(c) In your opinion, is your patient motivated to return to work?

## 7. Physician Information

Attending Physician's Name (Print) \_\_\_\_\_ Degree \_\_\_\_\_ Specialty \_\_\_\_\_

Address (No, Street, City, State, ZIP Code) \_\_\_\_\_ Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Signature [Signature] Date (MM/DD/YYYY) 6/20/2014

WKAB  
 GC-1455-26 (7-13) ©

Claim Number: 9452367

Patient Name (Last, First, Middle Initial) Required  
DAVIS, ARTHUR

## 8. Regulation Notice

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

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HMA GRASSLAND  
2339 Hillsboro Road, Suite 100

Patient Name: Arthur C Davis  
DOB: REDACTED  
Gender: Male

## Allergies

- EGGS 05/29/2014 Hives Active
- FISH 05/29/2014 Active
- WASPS 05/29/2014 Active
- Mobic \*ANALGESICS - ANTI-INFLAMMATORY\* 05/29/2014 Dizziness Active
- NUTS 05/29/2014 Active

## Medications

- Lisinopril-Hydrochlorothiazide (20-25MG Tablet, 1 Oral daily, Taken starting 06/11/2014) Active.
- Pamelor 25MG, one Capsule at bedtime x 5 nights, then two capsules at bedtime thereafter, #60, 05/29/2014, Ref. x1. Active.
- CloNIDine HCl (0.1MG Tablet, 1 Oral three times daily prn SBP >160, Taken starting 01/13/2014) Active. (PT NO LONGER TAKING)
- Atenolol (100MG Tablet, 1 (one) Tablet Oral daily, Taken starting 08/05/2013) Active. (PT NO LONGER TAKING)
- Physical Therapy (1 (one) Misc three times per week, Taken starting 09/25/2013) Active. (FINISHED/ Dx- frozen shoulder; eval and treat, massage and ROM)
- Naproxen (500MG Tablet, 1 (one) Tablet Oral two times daily, Taken starting 09/27/2013) Active. (PT NO LONGER TAKING)
- Diazepam (5MG Tablet, 1 (one) Tablet Oral at bedtime, Taken starting 01/13/2014) Active. (PT NO LONGER TAKING)
- Spironolactone (25MG Tablet, 1 Oral daily) Active.
- Lotrisone (1-0.05% Cream, 1 External two times daily, Taken starting 05/13/2014) Active.
- Flonase (50MCG/ACT Suspension, 1 Nasal two times daily, as needed, Taken starting 01/22/2014) Active.
- Bystolic (10MG Tablet, 1 Oral daily, Taken starting 01/15/2014) Active.
- Dulera (200-5MCG/ACT Aerosol, 1 (one) Aerosol Inhalation two times daily, Taken starting 01/15/2014) Active.
- CeleBREX (200MG Capsule, 1 Oral daily, Taken starting 01/13/2014) Active.
- Hydrocodone-Acetaminophen (5-325MG Tablet, 1-2 Tablet Oral Q6hr prn, Taken starting 09/27/2013) Active.
- AmlODIPine Besylate (10MG Tablet, 1 Oral daily, Taken starting 07/12/2013) Active.
- Ventolin HFA (108 (90 Base)MCG/ACT Aerosol Soln, 1 Inhalation daily, Taken starting 05/29/2013) Active.
- Advair Diskus (250-50MCG/DOSE Aero Pow Br Act, 1 Inhalation two times daily, Taken starting 07/19/2013) Active.
- Omeprazole (20MG Capsule DR, 1 Oral two times daily, Taken starting 07/19/2013) Active.
- EpiPen 2-Pak (0.3MG/0.3ML Device, 1 Injection as directed, Taken starting 06/13/2012) Active.
- ZyrTEC Allergy (10MG Capsule, 1 Oral daily, Taken starting 11/21/2011) Active.

Attention Wanda Greene Celestine  
Senior technical Specialist  
Phone 800-354-1779  
Fax 866-667-1987

Disability Claim#9452367

[Quoted text hidden]

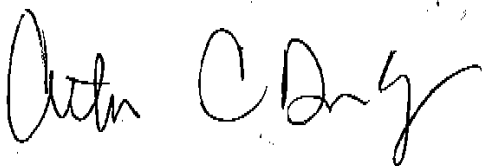
Art Davis  
To REDACTED  
REDACTED

Thu, Jun 19, 2014 at 10:34 AM

Today I had an appointment with my pain management doctor Breena Green Murfreesboro Medical Clinic 1272 Garrison Drive Suite 303, Murfreesboro TN 37129. She does not recommend Nerve Burning because it will not elevate the burning in my feet. She has recommended to continue taking Tramadol and to return in 6 weeks.

Previous appointment was with Dr. Jason Knox of Neuhaus Foot and Ankle StoneCrest Boulevard, Smyrna, TN, United States on June 9<sup>th</sup>, he recommended I see a back surgeon.

Dr. Subir Prasad, Heritage Medical Associates Saint Thomas West Hospital 4230 Harding Road Nashville, TN 37205 on May 29<sup>th</sup>, he said there was no nerve damage in my legs.



<https://mail.google.com/mail/u/0/?ui=2&ik=38d53bc76c&view=pt&search=sent&th=146b...> 6/19/2014

6/16/2014 2:42 PM

AETNA -> 16150677974

Page 2 of 2

Print Letter

Page 1 of 1

482122  
Davis



PO Box 14560  
Lexington, KY 40512-4560  
SHAWNDR LEE  
STD BENEFIT MANAGER  
Phone: 800-354-1779  
Fax: 1-866-667-1987

06/16/2014

Dr. Brenna Green  
1272 Garrison Dr., Suite 302  
Murfreesboro TN - 37129

Group Control No: 0476626  
Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

Dear Dr. Green:

The Dell Inc. group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna). To properly evaluate their eligibility for continued disability benefits, information is needed from your office.

Please include current office and/or chart notes, along with any medical documentation you may have including, labs, blood work, physical exam, MRI/x-ray, and the results of any other diagnostic test from the last 2 office visit.

Dell Inc.'s Program requires a clinical review of the medical appropriateness for your patient's work absence. Your office can fax the documents to 1-866-667-1987 or mail them to:

Aetna Life Insurance Company  
Dell Inc. LTD Program  
PO Box 14560  
Lexington, KY 40512-4560

It is important to understand that if we do not receive the requested documentation by July 1, 2014 your patient's case may be closed and benefits may be terminated.

Should you have any questions regarding your claim, please call 800-354-1779 and an Aetna Customer Service Representative will be happy to assist you.

Sincerely,

Wanda Greene Celestine  
Senior Technical Specialist  
Aetna Life Insurance Company

6/16/2014 2:42 PM

AETNA -> 16158677974

Page 1 of 2



## Fax Message

482122  
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**To:** Dr. Green  
**Fax:** 6158677974  
**From:** Greene Celestine, Wanda  
**Date:** 6/16/2014 2:42 PM  
**Pages:** 1 of 2 (including this page)  
**Subject:** Arthur Davis

---

**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.



## Murfreesboro Medical Clinic

1272 Garrison Drive  
Murfreesboro, TN 37129  
615-867-7971 www.mmmclinic.com 1-800-842-6692

### Spine Joint and Pain Center

PatientName: ARTHUR C. DAVIS EMRN # 482122

#### Reason For Visit

Patient is here today for follow-up regarding chronic low back pain s/p MVA 9/27/13.

#### HPI

ARTHUR DAVIS returns to the office today for follow-up regarding chronic low back pain s/p MVA on 9/27/13. (Please see initial visit for details.) The patient has also had right and left RC surgeries and recent left knee ACL repair by Dr. Renfro. He states that his left knee is feeling better. In the interim since his last visit, he did have an injection for his coccyx pain but he did not feel that it helped much with his symptoms. He continues to have low back pain but denies any symptoms in the legs other than burning in the feet. All of his symptoms are most bothersome at night. He denies any weakness on today's visit. Currently, his pain is described as a constant sharp, throbbing and aching pain rated 8/10 in intensity. He denies any changes or loss of control of his bowel or bladder. He is currently taking Celebrex which helps minimally. Tramadol does give him some relief. He did not experience any relief with gabapentin and he did not tolerate a Cymbalta trial. He has not tried Lyrica. He is unsure if he wants to pursue any other injections at this juncture. MRI L-spine shows DDD at L4-5/L5-S1 facet arthropathy.

Historical information from initial visit: ARTHUR DAVIS is a pleasant 50 year old male who presents today for evaluation of chronic low back pain s/p MVA on 9/27/13. The patient first experienced about one year of low back pain about 20-21 years ago after a MVA. Once this calmed down, he was quite active and his symptoms were controlled with occasional Celebrex and stretching. On 9/27/13, the patient was in a Mazda 6 which was stopped and subsequently rear-ended by a 4-door type sedan traveling about 15-20 mph. The patient did not lose consciousness nor did airbags deploy. He did not notice immediate pain and therefore did not go to the ED. About a week after the accident, he developed numbness and tingling in the posterior aspects of his legs as well as back spasms and tailbone pain. He went to PT and his leg symptoms improved but his low back/tailbone pain seemed to increase. He then had shoulder surgery and after that went to PT for his shoulders and his back. This seemed to further aggravate his low back pain. He currently has pain in the low back and coccyx area. He denies pain, numbness, tingling or weakness in the legs but does note some burning in his feet. His pain is described as a constant aching and throbbing pain rated 8/10 in intensity. He denies any changes or loss of control of his bowel or bladder. Standing, lying in bed, bending, stairclimbing and sitting do aggravate his pain. and elevation of his legs do provide some relief. He does sleep in a recliner. He does note some benefit from Tylenol and Advil and takes tramadol at bedtime to help him sleep. He does not think the tramadol is working as well as it did initially. He has not had any injections or bracing for his pain. He did see a spine surgeon, Dr. Kauffman, who ordered more PT. The patient went "all out" for PT and has reportedly torn his left ACL which is being operated on by Dr. Renfro on 4/18/14. He has also reportedly torn his right medial mensicus. He has been on short-term disability since October 10, 2013 which apparently will switch over to LTD in April. He does have a claim pending against the other driver's insurance company.

#### Allergies

Rec: 06May2014. List Reconciled and Reviewed.  
OxyCODONE HCl CAPS; Adverse Reaction; Itching.

#### Current Meds

Rec: 06May2014, List Reconciled and Reviewed.

TraMADol HCl 50 MG Oral Tablet;; RPT

ProAir HFA 108 (90 Base) MCG/ACT Inhalation Aerosol Solution;; RPT

Bystolic 10 MG Oral Tablet;; RPT

Zyrtec Childrens Allergy 10 MG Oral Tablet Chewable;; RPT

AmlODIPine Besylate 10 MG Oral Tablet;; RPT

Omeprazole 20 MG Oral Tablet Delayed Release;; RPT

Flonase 50 MCG/ACT Nasal Suspension;; RPT

Spironolactone 25 MG Oral Tablet;; RPT

Advair Diskus 250-50 MCG/DOSE Inhalation Aerosol Powder Breath Activated;; RPT

CeleBREX 200 MG Oral Capsule;; RPT

Lisinopril-Hydrochlorothiazide 20-25 MG Oral Tablet;; RPT

CloNIDine HCl 0.1 MG Oral Tablet;; RPT

Valium 5 MG Oral Tablet;; RPT

Gabapentin 300 MG Oral Capsule;; RPT

DULoxetine HCl 60 MG Oral Capsule Delayed Release Particles;TAKE 1 CAPSULE DAILY.; Rx.

#### **Active Problems**

Acrochordon (701.9)

Asthma (493.90)

Benign Essential Hypertension (401.1)

Esophageal Reflux (530.81)

Intervertebral Disc Degeneration (722.6)

Lower Back Pain (724.2)

Lumbar Disc Degeneration (722.52)

Lumbar Spondylosis (L5 - S1) (721.3)

Somatic Dysfunction Of Lumbar Region (739.3)

Somatic Dysfunction Of Pelvic Region (739.5)

Somatic Dysfunction Of Rib Cage (739.8)

Somatic Dysfunction Of Thoracic Region (739.2).

#### **PMH**

Asthma (493.90)

Hypertension (401.9)

Peptic Ulcer (V12.71)

Somatic Dysfunction Of Sacroiliac Region (739.4).

#### **PSH**

Rotator Cuff Repair; bilateral

Sinus Surgery.

#### **Family Hx**

Maternal history of Family Health Status Of Mother - Deceased

Maternal history of Father Deceased At Age \_\_\_\_

Family history of Hypertension

Family history of Rheumatoid Arthritis.

#### **Personal Hx**

Denied Alcohol

Being A Social Drinker

Exercising Regularly; Elliptical

Living In An Apartment

Marital History - Divorced

Never A Smoker

Occupation:: Sales for Dell.

#### **ROS**

An interval history including a 10-point ROS including musculoskeletal, GI and neurological systems, PMH, SocHx and FamHx was reviewed in the follow-up Medical Questionnaire signed and dated 05/06/2014 and no changes were noted thus no further comments are necessary.

#### **Vital Signs**



Recorded by Suits,Christy on 06 May 2014 10:08 AM

BP:130/75,

Height: 72.000000 in, Weight: 240.000000 lb, BMI: 32.6 kg/m2,

O2 Sat: 98 (%SpO2),

BSA Calculated: 2.30 ,

BMI Calculated: 32.51.

#### Physical Exam

ARTHUR DAVIS is a pleasant 50 year old overweight male who was in no apparent distress. He was alert, cooperative and answered questions appropriately throughout the exam. No obvious rashes or discolorations were noted in exposed areas on the skin. There is no edema noted in the lower limbs. He transfers and ambulates independently. Manual motor testing reveals functional motor strength in the lower limbs without focal deficit. Muscle stretch reflexes remain symmetric (depressed at the Achilles/hamstrings). Straight leg raising is negative in the lower limbs.. There was no evidence of ataxia with gait.

#### Assessment

1. Chronic low back pain s/p MVA on 9/27/13 symptoms worse at night with burning in the feet. Unchanged.
2. Chronic coccydynia s/p MVA in 9/27/13. Unchanged.
3. Bilateral knee pain - reported left ACL tear, right medial meniscus tear. S/P recent left knee surgery by Dr. Renfro.
4. Bilateral shoulder pain with previous RC surgeries bilaterally. Stable.

#### Orders

CSMD-TN Reviewed; Requested for: 06 May 2014.

#### Plan

The above impressions and a number of treatment options were discussed with the patient and he was agreeable to the following plan designed to optimize function, reduce pain and improve quality of life:

1. Physical Therapy/Exercise/Lifestyle Modification: I have encouraged the patient to continue with his home exercise program on a regular basis as a lifelong activity. I have given additional exercises to incorporate into his home program.

Encouraged weight management and avoidance of inflammatory foods. Information given at a previous visit.

From our standpoint, would need FCE for disability paperwork.

#### 2. Medications:

- a. Start Lyrica 75 mg 1-2 PO QHS. Side effects discussed.
- b. Continue Tylenol/Aleve prn
- c. Continue tramadol prn - no Rx needed today.
- d. Stopped Cymbalta - not tolerated/Gabapentin not effective

#### 3. Tests:

BLL EMG ordered.

4. Interventional procedures: No response to coccyx injection. Consider lumbar MBB.

Records from Dr. Renfro reviewed.

5. The patient was previously educated on signs and symptoms that should prompt emergent treatment such as bowel or bladder incontinence, saddle anesthesia and or significant weakness in the arms or legs.

6. I will see the patient back in 4-6 weeks to evaluate his progress. Should he have any questions, concerns or a flare in symptoms in the interim, he may call the office at any time.

7. Pain Disability Questionnaire/CCESD-R Results 3/25/14: ccesdr-27, pdq-131/150

All of the patient's questions were answered to his apparent satisfaction. Thank you for allowing me to participate in the care of your patient, ARTHUR DAVIS.

**Signature**

Electronically signed by : BRENN A GREEN D.O.; 05/06/2014 12:14 PM CST.

Reviewed by : NICHOLAS COTE D.O.; 05/06/2014 5:19 PM CST,

**Murfreesboro Medical Clinic**

1272 Garrison Drive

Murfreesboro, TN 37129

615-867-7971 www.mmcclinic.com 1-800-842-6692

**Spine Joint and Pain Center****PatientName: ARTHUR C. DAVIS EMRN # 482122****Procedure**

Procedure: Coccyx Injection

Clinical Indications: Lumbar degenerative disc disease/ lumbar radiculitis/ Lumbar Spinal Stenosis/  
Post-Laminectomy

Risks and Benefits and alternative treatments were reviewed with the patient. The patient then agreed and signed a written informed consent for the procedure listed above.

Risks: Bleeding, infection, nerve injury, dural injury, paralysis, headache, increased pain, allergic or adverse reaction to the needle or medications, kidney or internal organ injury, vasovagal reaction, seizure, and no response to the procedure. The patient was aware that he would have an increased risk of bleeding due to taking ASA yesterday.

Benefits: Decreased pain, increased function, and/or confirming clinical diagnosis.

Physician performing the procedure: Brenna R.E. Green, DO

Procedure: After the patient was identified using name and date of birth, we confirmed the side, level, and type of procedure being performed for the patient. Prior to initiating the procedure the patient was educated on the risks, benefits, and alternative treatment options and written informed consent was obtained. The patient was then escorted to the fluoroscopy suite and placed on the table in the prone position. The patient's vital signs were monitored before, during, and after the procedure. Under fluoroscopic guidance the appropriate side and level was identified and the target point on the skin marked. The skin was prepped and draped in a sterile manner.

With fluoroscopic guidance the sacrococcygeal junction was identified. After the target entry point was identified and marked a 25 g 1 1/2 inch needle was used to inject 1-2 mls of 1% Lidocaine for local anesthetic. Then a 25 g 3.5 inch needle was directed towards the sacrococcygeal junction in the lateral view. Caution was used not to advance the needle beyond the anterior border of the sacrum. an AP view was used to confirm midline positioning. After entering the joint space there was negative aspiration of CSF and heme. The final position of the needle was confirmed in both the AP and lateral views. In the lateral and AP views after repeat negative aspiration of heme and CSF, 0.5 - 1 ml of Omnipaque (contrast) was injected under real-time fluoroscopy. No vascular or dural uptake was noted. Dye spread was noted to be in epidural space in both the AP and lateral views. Then a 2 ml solution containing 1ml of 10mg/ml Dexamethasone mixed with 1 mls of 1% PF Lidocaine was injected. The needle was withdrawn. The injection site was cleaned and covered with a sterile bandage.

The patient tolerated the procedure well: Yes

Complications: None

The patient was transported to the recovery area for 20 minutes, where he (after meeting discharge criteria) was discharged home with a copy of the post-procedure care instructions and follow-up instructions.

**Signature**

Electronically signed by : BRENN A GREEN D.O.; 04/14/2014 2:52 PM CST.

Reviewed by : NICHOLAS COTE D.O.; 04/22/2014 11:32 AM CST.

## Medical Professionals List

**Return completed form to:**  
Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
**Fax: 1-866-667-1987**

In the space provided below, please list the complete names, specialty, addresses, phone and fax numbers of all medical professionals you have consulted for the past two years. If necessary, you may use the back of this form to list additional medical providers, pharmacies, hospitals, or any other pertinent information regarding your disability.

Employee Name	Claim #
DAVIS, ARTHUR	Claim Number: 9452367

Medical Provider / Hospital / Pharmacy: Premier Orthopaedics + Sports  
Specialty: Joint replacement, Sports Medicine Period Consulted: 10/7/13 - 5/23/14  
Address: 394 Harding Place,  
Nashville City: TN State: 37211 Zip Code:  
Phone: (615) 834-4482 Fax:

Medical Provider / Hospital / Pharmacy: Premier Orthopaedics + Sports  
Specialty: Spine Surgery Period Consulted: 10/31/13 - 12/19/13  
Address: 394 Harding Place  
City: Nashville State: TN Zip Code: 37211  
Phone: (615) 834-4482 Fax: \_\_\_\_\_

Medical Provider / Hospital / Pharmacy: Dr. Nicholas Kauffman Cote MMC  
Specialty: Family Medicine Period Consulted: Jan 16, 28 + March 17  
Address: 1272 Garrison Drive  
City: Murfreesboro State: TN Zip Code: 37129  
Phone: (615) 893-4480 Fax:

Medical Provider / Hospital / Pharmacy: Dr. Breanna Green Murfreesboro Medical Clinic  
Specialty: Spine Pain Period Consulted: May 26, April 16th  
Address: 1272 Garrison Drive  
City: Murfreesboro State: TN Zip Code: 37129  
Phone: (615) 867-7971 Fax: \_\_\_\_\_

Medical Provider / Hospital / Pharmacy: Tad Yoneyama Heritage Medical  
Specialty: Internist Period Consulted: 1/13/14 5/27/14  
Address: 2339 Hillsboro Road  
City: Franklin State: TN Zip Code: 37069  
Phone: (615) 224-1775 Fax: (615) 916-3903



0612140038

Employee Name DAVIS, ARTHUR	Claim # Claim Number: 9452367
--------------------------------	----------------------------------

Medical Provider / Hospital / Pharmacy: Dr. Subir Prasad Heritage Medical Assoc  
 Specialty: Neurology Period Consulted: May 29, 2014  
 Address: Saint Thomas West 4230 Harding Road  
 City: Nashville State: TN Zip Code: 37205  
 Phone: (615) 425-7605 Fax: (615) 916-3953

Medical Provider / Hospital / Pharmacy: Dr. Jason Knox Neuhaus Foot & Ankle  
 Specialty: Podiatrist Period Consulted: \_\_\_\_\_  
 Address: Stonecrest Physicians Building 300 Stonecrest Blvd Ste 450  
 City: Smarna State: TN Zip Code: 37167  
 Phone: (615) 220-8788 Fax: \_\_\_\_\_

Medical Provider / Hospital / Pharmacy: \_\_\_\_\_  
 Specialty: \_\_\_\_\_ Period Consulted: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Medical Provider / Hospital / Pharmacy: \_\_\_\_\_  
 Specialty: \_\_\_\_\_ Period Consulted: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Medical Provider / Hospital / Pharmacy: \_\_\_\_\_  
 Specialty: \_\_\_\_\_ Period Consulted: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Medical Provider / Hospital / Pharmacy: \_\_\_\_\_  
 Specialty: \_\_\_\_\_ Period Consulted: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_



0612140038



**aetna**<sup>SM</sup>

## Fax Message

---

**To:** DR. RENFRO  
**Fax:** 6158344722  
**From:** Greene Celestine, Wanda  
**Date:** 5/7/2014 2:10 PM  
**Pages:** 1 of 2 (including this page)  
**Subject:** ARTHUR DAVIS

---

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## Progress Note

<b>Patient Name:</b>	Arthur Davis, Jr.	<b>Visit Date:</b>	April 25, 2014
<b>Patient ID:</b>	687103	<b>Provider:</b>	R J. Renfro, MD
<b>Sex:</b>	Male	<b>Location:</b>	Harding Place
<b>Birthdate:</b>	REDACTED	<b>Location Address:</b>	394 Harding Place Suite 200 Nashville, TN 372113980
<b>Primary Care Provider:</b>	Tadayuki Yoneyama MD	<b>Location Phone:</b>	(615) 834-4482
<b>Referring Provider:</b>	Former Patient		

### Chief Complaint

- left knee

### History Of Present Illness

Arthur C. Davis Jr. is a 50 year old Black/African American male who presents today for post-op left knee scope.

He has slight swelling in the knee which would be expected. This therapy for his shoulders going well and he just simply needs more strengthening her shoulder.

We discussed light strengthening do on his own for now. He may higher a trainer in a month. The followup in one month

### Past Medical History

Disease Name	Date Onset	Notes
Asthma	--	--
Degeneration of lumbar Intervertebral disc	11/07/2013	--
High blood pressure	--	--
Rotator Cuff Sprain/Tear	10/07/2013	--
Rotator Cuff Tear, Non-Trauma	10/07/2013	--
Sciatica	11/02/2013	--
Sprain/Strain	10/18/2013	--
Sprain/Strain, Lumbar	10/18/2013	--
Tear, Medial Meniscus	01/28/2014	--

### Past Surgical History

Procedure Name	Date	Notes
Hernia	--	--
Joint surgery (arthroscopic or open)	2004	left knee
Sinus Surgery	--	--

### Medication List

Name	Date Started	Instructions
Advair Diskus Inhalation disk with device 250-50 mcg/dose	07/19/2013	--
amlodipine Oral tablet 10 mg	09/10/2013	--
Celebrex Oral capsule 200 mg	07/12/2013	--
ciprofloxacin Oral tablet 500 mg	07/11/2013	--
clotrimazole-betamethasone Topical cream 1-0.05 %	08/13/2013	--
fluticasone Nasal spray,suspension 50 mcg/actuation	07/19/2013	--
lisinopril-hydrochlorothiazide Oral tablet 20-25 mg	09/23/2013	--
methylprednisolone Oral tablets,dose pack 4 mg	09/19/2013	--
metoprolol succinate Oral tablet extended release 24 hr 50 mg	07/31/2013	--

[Digital Signature Validated]



naproxen Oral tablet 500 mg	09/27/2013	--
Neurontin oral capsule 300 mg	12/19/2013	1 capsule (300 mg) by oral route every eight hours for 30 days
omeprazole Oral capsule, delayed release (DR/EC) 20 mg	07/19/2013	--
potassium chloride Oral tablet extended release 10 mEq	08/06/2013	--
prednisone Oral tablet 20 mg	09/27/2013	--
spironolactone Oral tablet 25 mg	08/13/2013	--
Ultram Oral tablet 50 mg	02/26/2014	take 1 tablet (50 mg) by oral route every 6 hours as needed for 15 days

### Allergy List

Allergen Name	Date	Reaction	Notes
codeine sulfate	--	itching/rash	--

### Family Medical History

Disease Name	Relative/Age	Notes
Family history of arthritis	/	--
Family history of heart disease	Mother/ /	--
	Mother/	

### Social History

Finding	Status	Start/Stop	Quantity	Notes
Alcohol Intake	Never	--/--	--	--
Tobacco	Never	--/--	--	--

### Review of Systems

#### Constitutional

- Denies : fatigue, weight loss, weight gain

#### Gastrointestinal

- Denies : heartburn, hematemesis

#### Genitourinary

- Denies : dysuria

#### Neurologic

- Denies : muscular weakness, incoordination, tingling or numbness, loss of balance

#### Musculoskeletal

- Admits : joint pain, night pain

#### Psychiatric

- Denies : depression

### Vitals

Date	Time	BP	Position	Site	L\R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m <sup>2</sup>	BSA m <sup>2</sup>	O2 Sat	HC
12/19/2013	03:05 PM							18		236lbs 0oz	6' 0"	32.01	2.33		

### Assessment

- Rotator Cuff Sprain/Tear 840.4
- Tear, Medial Meniscus 836.0

[Digital Signature Validated]

**Plan**

**Instructions**

- o This note was generated using EMR and voice recognition software and therefore may contain unedited errors.

**Disposition**

- o Instructed on home exercises
- o RTC in 4 weeks

**Electronically Signed by:** R J. Renfro, MD -Author on April 25, 2014 11:43:43 AM

[Digital Signature Validated]

**PREMIER ORTHOPAEDIC SURGERY CENTER**

394 Harding Place, Suite 100

Nashville, TN 37211

Tel: (615) 332-3600 Fax: (615) 332-3630

**OPERATIVE REPORT****PATIENT NAME:** DAVIS, ARTHUR C.**MEDICAL RECORD #:** 17510**SURGEON:** JAMES RENFRO, M.D.**DATE OF SURGERY:** 04/18/2014**PREOPERATIVE DIAGNOSIS:**

Medial and lateral meniscus tears, left knee.

**POSTOPERATIVE DIAGNOSIS:**

Medial and lateral meniscus tears, left knee.

**PROCEDURE PERFORMED:**

Partial medial and lateral meniscectomy, left knee.

**ASSISTANT:**

Joy Rivard.

**ANESTHESIA:**

General.

**FINDINGS:** The patient had a bucket-handle tear of his medial meniscus that had detached posteriorly, which was basically flipped up anteriorly and pulled it on itself. Lateral meniscus had radial tearing in his middle-third. There was a large osteophyte at the stump of where the ACL used to be abutting the trochlea in full extension creating an essence of cyclops type lesion. This was hard bony mass.

**TECHNIQUE:** After satisfactory anesthesia was obtained, the left lower extremity was prepped and draped in a sterile fashion, exsanguinated, and tourniquet was inflated. A standard anterior arthroscopy portal was established. The knee was fully inspected with the findings as noted above. There was a large bony mass stated at the base of the ACL. We used the baskets and a bur to remove this. We then used the shaver and debrided the tear of the lateral meniscus. It was just an inner rim tear and we could smooth it satisfactorily with a shaver with teeth. Likewise, we used a shaver and we just continuously debrided on this bucket-handle medial meniscus tear to leave chute the fragments and remove them. We carefully probed. Remainder of the meniscus appeared satisfactory. Patellofemoral joint was very healthy. We removed our instruments, expressed the fluid, and closed the portals with 3-0 nylon. A sterile dressing was applied. The patient was sent to the recovery room in satisfactory condition.

-----Begin Electronic Signature-----



Signed By: James Renfro, M.D.

On Date: 04/22/2014 09:33:47 CDT

-----End Electronic Signature-----

James Renfro, M.D.

IOB#: 327050

JR: med: vsm/rja

D: 04/18/2014

T: 04/19/2014

**OPERATIVE REPORT - PAGE 1 of 1**

3/18/2014 4:25 PM

AETNA -&gt; 16158966212

Page 3 of 3



## Facsimile Transmittal Sheet

To:	From:
Dr. Cote	Aetna Disability
Employer:	Date:
Dell Inc	03/18/2014
Fax Number: 615-895-6212	CLAIM NUMBER:
	9452367
Phone number:	Sender's Phone Number:
	800-354-1779
	Sender's FAX Number:
	1-855-667-1987
Re: MR. ARTHUR DAVIS Date of Birth: [REDACTED]	Total No. of Pages Including Cover:

Urgent For Review Please Comment xx Please Reply Please Recycle

Dear Dr. Cote:

We are currently evaluating Mr. Davis for eligibility to receive LTD benefits. Please submit all the available records to Aetna. Mr. Davis has signed a release to have those records submitted to Aetna. Thanks, Maribel

Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

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Enclosed:

Premier  
Radiology  
MURFREESBORO



Saint Thomas  
Health

Premier Radiology Murfreesboro  
1840 Medical Center Parkway, Suite 101  
Murfreesboro, TN 37129  
Phone #: (615)896-1234  
Fax: (615)234-1504

Name: ARTHUR DAVIS  
Patient ID: 1000977943  
Secondary ID:  
DOB: REDACTED  
Acc #: 3338109

Exam Date: 11/06/2013 04:17 PM  
Exam Name: MR Lumbar spine w/o contrast | 72148  
Referrer: Christopher Kauffman, MD  
2nd Referrer:

PROCEDURE: MRI LUMBAR SPINE WITHOUT CONTRAST

TECHNIQUE: Magnetic resonance imaging of the lumbar spine was performed using standard pulse sequences without contrast material. CPT 72148

HISTORY: Sclatica CENTER LOWER BACK PAIN.

COMPARISONS: None .

FINDINGS:

The vertebral body heights are well maintained. No subluxation is present. There is no abnormal marrow signal. The conus tip is located at L1-L2. The conus and filum terminale are normal in appearance. No paravertebral soft tissue abnormalities are present. Disc desiccation and mild intervertebral disc height loss at L3-L4.

L1-L2: Mild broad-based posterior disc bulge with no spinal canal stenosis or neuroforaminal narrowing.

L2-L3: Mild broad-based posterior disc bulge with no spinal canal stenosis or neuroforaminal narrowing.

L3-L4: Broad-based posterior disc bulge with facet joint and ligamentum flavum hypertrophy. No spinal canal stenosis or significant neuroforaminal narrowing.

L4-L5: Broad-based posterior disc bulge with facet joint and ligamentum flavum hypertrophy. No significant spinal canal stenosis. Mild RIGHT neural foraminal narrowing noted.

L5-S1: Mild broad-based posterior disc bulge with facet joint and ligamentum flavum hypertrophy. No spinal canal stenosis or RIGHT neural foraminal narrowing. There is mild LEFT neuroforaminal narrowing.

IMPRESSION:

1. Multilevel disc bulges with no spinal canal stenosis.
2. Multilevel facet joint/ligamentum flavum hypertrophy, with mild RIGHT neural foraminal narrowing at L4-L5 and mild LEFT neural foraminal narrowing at L5-S1.
3. Mild degenerative disc disease at L3-L4.

ws:MTISTN-READING0

Electronically Signed by: Eric Dame M.D.  
Electronically Signed on: 11/06/2013 11/6/2013 4:26:52 PM

Reviewed by: NICHOLAS COTE D.O. Jan 23 2014 1:06PM CST 1/23/2014

<https://ris.premierradiology.com/Reports/printReportCustom.aspx?acc=3338109>

12/27/2013

**nFM New Visit (non-COMP)**

**Murfreesboro Medical Clinic**  
1272 Garrison Drive  
Murfreesboro, TN 37129  
www.mmclinic.com (615) 893-4480

Patient: ARTHUR C. DAVIS

**REDACTED**

EMRN: 482122

Encounter Date: Jan 16 2014 8:00AM

**History of Present Illness**

Patient here today to est. care.

States that he had L rotator cuff surgery in October. Sx was with Premiere Orthopedics; in Sept "tore both my rotator cuffs". he was moving the lawn when it happened, felt like the "arms were pulled out of socket". Right is scheduled for then end of Jan (1/31/14).

Was also in a car accident 9/27/13 where was "hit from behind" and this seemed to exacerbate the chronic LBP and made it now daily. has had chronic low back pain that he has "dealt with" by yoga and stretching (no manipulation) has had some PT for the low back at STAR PT in M'boro. Pain is still present. It is currently 7/10, gets to 8/10 at night. Does flare up to 10/10. Has taken mult pain meds and they did not help ("all the codienes and tramadol"). Has been on mult meds to help him sleep. Pain is worst at night.  
Has not been to work since Oct as he is on disability from work d/t shoulder pain and surgeries.

He has had MRI of the L-spine. has not had any injections at this point.

He is trying to exercise daily. He does use an elliptical. does some step aerobics while playing video games to try to "block out the pain".

Last eye exam was 1 year ago.

Will get me the date of last TDAP, says that it has been within the past 10 years.

**Review of Systems**

Constitutional: as noted in HPI.  
ENT: negative except as noted per HPI.  
Cardiovascular: negative except as noted per HPI.  
Respiratory: negative except as noted per HPI.  
Gastrointestinal: negative except as noted per HPI.  
Genitourinary: negative except as noted per HPI.  
Musculoskeletal: as noted in HPI.

**Active Problems**

1. Benign Essential Hypertension 401.1
2. Esophageal Reflux 530.81
3. Intervertebral Disc Degeneration 722.6
4. Lower Back Pain 724.2

**Social History**

- Never A Smoker

**Current Meds**

1. Advair Diskus 250-50 MCG/DOSE Inhalation Aerosol Powder Breath Activated; Therapy:

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1 of 3

3/24/14 1:05:39 PM

**nFM New Visit (non-COMP)**

Patient: ARTHUR C. DAVIS  
 Encounter: Jan 16 2014 8:00AM

EMRN: 482122

- 19Jul2013 to  
 2. CeleBREX 200 MG Oral Capsule; Therapy: 12Jul2013 to  
 3. Lisinopril-Hydrochlorothiazide 20-25 MG Oral Tablet; Therapy: 12Jul2013 to  
 4. Potassium Chloride ER 10 MEQ Oral Tablet Extended Release; Therapy: 06Aug2013 to

**Allergies**

1. OxyCODONE HCl CAPS

**Immunizations**

No Immunizations Recorded

**Vitals****Vital Signs [Data Includes: Current Encounter]**

16Jan2014 08:29AM

BMI Calculated: 32.37

BSA Calculated: 2.3

Height: 72 in

Weight: 239 lb

Blood Pressure: 126 / 82

Heart Rate: 82

O2 Saturation: 98

**Physical Exam**

**General Appearance:** Well-appearing. Alert. Well developed. In no acute distress.

**Head and Eyes:** No evidence of a head injury. Head normocephalic. PERRL.

**Neurological and Psychiatric** the level of consciousness was normal, the attitude was normal, the mood was normal and the affect was normal. Normal sensation. Normal gait and station.

**Musculoskeletal:** Inspection/palpation of joints, bones, and muscles normal. Normal range of motion. Normal muscle strength/tone.

**Lumbosacral Spine:** Appearance: Normal. Pain at the bilateral SI Jts, some tenderness at the sacrococcygeal jt. ROM: Deferred.

**Lower Extremity Motor Testing:** Foot and ankle strength was normal bilaterally. Knee strength was normal bilaterally.

**Hip strength** was normal bilaterally. (DTR 2/4 bilaterally in the LE) Special Tests: negative Straight Leg Raise.

**Cardiovascular:** Normal pulses. No edema or varicosities.

**Assessment**

1. Lower Back Pain 724.2
2. Benign Essential Hypertension 401.1
3. Esophageal Reflux 530.81
4. Intervertebral Disc Degeneration 722.8
5. Somatic Dysfunction Of Sacroiliac Region 739.4
6. Asthma 483.90

**Plan**

**Hypertension:** The Impression is essential hypertension. Currently, the condition is stable and responding to treatment. There are no changes in medication management. Other planned treatment includes an exercise regimen, dietary modification and weight loss, low sodium diet and handout given. The plan was discussed with the patient. (FU in 2-3 mo).

**GERD:** Currently, the condition is mild and responding to treatment. Treatment plan includes weight loss.

**Low Back Pain:** Impression: myofascial back pain. The patient's pain control has been adequate. There are no changes in medication management. Other planned treatment includes physical therapy (with Results only) and manipulation (will schedule OMM in 2 wks so that PT has some time to loosen him up for me. ). The plan was

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2 of 3

3/24/14 1:05:39 PM

**nFM New Visit (non-COMP)**

Patient: ARTHUR C. DAVIS  
Encounter: Jan 16 2014 8:00AM

EMRN: 482122

discussed with the patient.

**Signatures**

Electronically signed by : NICHOLAS COTE, D.O.; Jan 16 2014 9:16AM (Author)

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3 of 3

3/24/14 1:05:39 PM



**nOMM Note**

**Murfreesboro Medical Clinic**  
1272 Garrison Drive  
Murfreesboro, TN 37129  
www.mmclinic.com (615) 893-4480

Patient: ARTHUR C. DAVIS  
**REDACTED**

EMRN: 482122  
Encounter Date: Jan 28 2014 10:30AM

**Chief Complaint**

Back pain

**History of Present Illness**

HPI: Text Box:

Patient here today for severe back pain d/t car accident from Dec.27, 2013

Patient states that he has been seeing physical therapy 3 x per week; not getting very much better.

**Review of Systems**

Focused-Male OMM:

Constitutional: negative except as noted per HPI.

ENT: negative except as noted per HPI.

Cardiovascular: negative except as noted per HPI.

Respiratory: negative except as noted per HPI.

Gastrointestinal: negative except as noted per HPI.

Genitourinary: negative except as noted per HPI.

Integumentary and Breasts: negative except as noted per HPI.

**Active Problems**

1. Asthma 493.90
2. Benign Essential Hypertension 401.1
3. Esophageal Reflux 530.81
4. Intervertebral Disc Degeneration 722.6
5. Lower Back Pain 724.2
6. Somatic Dysfunction Of Sacroiliac Region 739.4

**Social History**

- Exercising Regularly
- Marital History - Divorced V61.03
- Never A Smoker
- Occupation:

**Denied**

- History of Alcohol

**Current Meds**

1. Advair Diskus 250-50 MCG/DOSE Inhalation Aerosol Powder Breath Activated; Therapy: 19Jul2013 to
2. Amlodipine Besylate 10 MG Oral Tablet; Therapy: 16Jan2014 to
3. CeleBREX 200 MG Oral Capsule; Therapy: 12Jul2013 to
4. Flonase 50 MCG/ACT Nasal Suspension; Therapy: 16Jan2014 to
5. Lisinopril-Hydrochlorothiazide 20-25 MG Oral Tablet; Therapy: 12Jul2013 to

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1 of 3

3/24/14 1:05:43 PM

**nOMM Note**

Patient: ARTHUR C. DAVIS  
Encounter: Jan 28 2014 10:30AM

EMRN: 482122

- 6. Omeprazole 20 MG Oral Tablet Delayed Release; Therapy: 16Jan2014 to
- 7. Potassium Chloride ER 10 MEQ Oral Tablet Extended Release; Therapy: 06Aug2013 to
- 8. Spirinolactone 25 MG Oral Tablet; Therapy: 16Jan2014 to

**Vitals****Vital Signs [Data Includes: Current Encounter]**

28Jan2014 10:51AM

BMI Calculated: 32.91

BSA Calculated: 2.32

Weight: 243 lb

Blood Pressure: 124 / 80

Heart Rate: 83

O2 Saturation: 98

**Physical Exam****OSTEOPATHIC:**

THORACIC: T 3-8 rotated right side/bent left

RIBS: Rib 3-5 is exhaled on the left

LUMBAR: L 3-5 rotated right side/bent left

PELVIS: \* left upslipped innominate; piriformis bilateral CS pt

**General Appearance.** Well-appearing. Alert. Well developed. In no acute distress. Uncomfortable.

**Head and Eyes.** No evidence of a head injury. Head normocephalic. PERRL.

**Neurological and Psychiatric** the level of consciousness was normal, the attitude was normal, the mood was normal and the affect was normal. Normal sensation. Normal gait and station.

**Assessment**

1. Lower Back Pain 724.2
2. Somatic Dysfunction Of Rib Cage 739.8
3. Somatic Dysfunction Of Pelvic Region 739.5
4. Somatic Dysfunction Of Lumbar Region 739.3
5. Somatic Dysfunction Of Thoracic Region 739.2

**Discussion/Summary**

**Back Pain - FM & IM:** Impression: myofascial back pain. The patient's pain control has been adequate. There are no changes in medication management. Other planned treatment includes physical therapy (cont this), manipulation and OMM as noted. Piriformis knee to chest. HAd significant ex improvement post treatment. The plan was discussed with the patient. Follow up in 4-5 wk

**Procedure****OMM:**

Informed consent given.

Thoracic: HVLA

Ribs: HVLA

Lumbar: HVLA CS MFR

Pelvis/Innominate: HVLA CS MFR

Pt tolerated procedure well.

(HVLA = High velocity Low Amplitude; CS = Counterstrain; MFR: myofascial release; CS: counterstrain; ME: muscle energy; FPR: Facilitated Postional Release)

Printed By: Christy Vance

2 of 3

3/24/14 1:05:44 PM

**nOMM Note**

Patient: ARTHUR C. DAVIS  
Encounter: Jan 28 2014 10:30AM

EMRN: 482122

**Signatures**

Electronically signed by : NICHOLAS COTE, D.O.; Jan 28 2014 2:26PM (Author)  
Electronically signed by : NICHOLAS COTE, D.O.; Jan 30 2014 5:29PM (Author)

Printed By: Christy Vance

3 of 3

3/24/14 1:05:44 PM

**nComp Visit****Murfreesboro Medical Clinic**

1272 Garrison Drive  
Murfreesboro, TN 37129  
www.mmclinic.com (615) 893-4480

Patient: ARTHUR C. DAVIS

**REDACTED**

EMRN: 482122

Encounter Date: Mar 6 2014 9:30AM

**Chief Complaint**

Complete physical

**History of Present Illness**

**Pertinent family history:** cardiovascular disease, but no osteoporosis, no psychiatric disorder, no chemical dependency, no prostate cancer, no colon cancer and no lung cancer.

**Safety elements used:** seat belt, safe driving habits, smoke detector, hot water temperature less than 120 degrees F, fall prevention measures, gun trigger locks and gun safe, but no sunscreen, no carbon monoxide detector, no bathroom grab bars and no CPR training for the patient.

The patient is being seen for a Health maintenance evaluation.

**General Health:** The patient's health since the last visit is described as good. He has regular dental visits. He denies vision problems. He denies hearing loss. Immunizations status: up to date.

**Lifestyle:** He does not have a healthy diet. He has weight concerns. He exercises regularly. He does not use tobacco. He denies drug use.

**Screening:** Cancer screening reviewed and current.

Metabolic screening reviewed and current.

Risk screening reviewed and current.

Depression screening tool used was the PHQ-2/9

1.) Little interest or pleasure in doing things? Not at all.

2.) Feeling down, depressed or hopeless? Not at all.

Patient here today for complete physical.

Eye exam was 2013

Never had colonoscopy.

Does see the dentist on a regular basis.

Had surgery in 1/31/14 on the right shoulder.

**Active Problems**

- Asthma 483.80
- Benign Essential Hypertension 401.1
- Esophageal Reflux 530.81
- Intervertebral Disc Degeneration 722.6
- Lower Back Pain 724.2
- Somatic Dysfunction Of Lumbar Region 739.3
- Somatic Dysfunction Of Pelvic Region 739.5
- Somatic Dysfunction Of Rib Cage 738.8
- Somatic Dysfunction Of Thoracic Region 739.2

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1 of 6

3/24/14 1:05:56 PM

**nComp Visit**

Patient: ARTHUR C. DAVIS  
Encounter: Mar 6 2014 9:30AM

EMRN: 482122

**Past Medical History**

- History of Peptic Ulcer V12.71
- History of Somatic Dysfunction Of Sacroiliac Region 739.4

**Surgical History**

Reviewed and Negative

**Family History**

- Maternal history of Family Health Status Of Mother - Deceased
- Maternal history of Father Deceased At Age \_\_\_\_

**Social History**

- Exercising Regularly
- Marital History - Divorced V81.03
- Never A Smoker
- Occupation:

**Denied**

- History of Alcohol

**Current Meds**

- Advair Diskus 250-50 MCG/DOSE Inhalation Aerosol Powder Breath Activated; Therapy: 19Jul2013 to
- AmLODIPine Besylate 10 MG Oral Tablet; Therapy: 16Jan2014 to
- Bystolic 10 MG Oral Tablet; Therapy: 06Mar2014 to
- CeleBREX 200 MG Oral Capsule; Therapy: 12Jul2013 to
- Flonase 50 MCG/ACT Nasal Suspension; Therapy: 16Jan2014 to
- Lisinopril-Hydrochlorothiazide 20-25 MG Oral Tablet; Therapy: 12Jul2013 to
- Omeprazole 20 MG Oral Tablet Delayed Release; Therapy: 16Jan2014 to
- ProAir HFA 108 (90 Base) MCG/ACT Inhalation Aerosol Solution; Therapy: 19Nov2013 to
- Spironolactone 25 MG Oral Tablet; Therapy: 16Jan2014 to
- TramADol HCl 50 MG Oral Tablet; Therapy: 08Mar2014 to
- ZyrTEC Childrens Allergy 10 MG Oral Tablet Chewable; Therapy: 08Mar2014 to

**Allergies**

- OxyCODONE HCl CAPS  
Adverse Reaction; Itching

**Immunizations**

Tdap --- Series1: 28Jan2005

**Vitals**

**Vital Signs [Data Includes: Last 1 Day]**

**06Mar2014 09:44AM**

BMI Calculated: 32.91

BSA Calculated: 2.32

Height: 6 ft

Weight: 243 lb

Blood Pressure: 124 / 80

Heart Rate: 78

O2 Saturation: 98

Printed By: Christy Vance

2 of 6

3/24/14 1:05:56 PM

## nComp Visit

Patient: ARTHUR C. DAVIS  
 Encounter: Mar 6 2014 9:30AM

EMRN: 482122

## Results/Data

COMP LAB [Data Includes: Last 1 Instance]

	27Feb2014	
WBC	4.3 x10 <sup>3</sup> /uL	
RBC	5.65 x10 <sup>6</sup> /uL	
HGB	14.8 g/dL	
HCT	45 %	
MCV	80.0 fL	
MCH	26.2 pg	
MCHC	32.7 g/dL	
RDW	13.8 %	
PLT	350 x10 <sup>3</sup> /uL	
MPV	8.2 fL	
GRAN%	36.2 %	
LYMPH%	49.2 %	
MONO%	8.6 %	
EO%	4.8 %	
BASO%	1.2 %	
GRAN#	1.5 x10 <sup>3</sup> /uL	
LYMPH#	2.1 x10 <sup>3</sup> /uL	
MONO#	0.4 x10 <sup>3</sup> /uL	
EO#	0.2 x10 <sup>3</sup> /uL	
BASO#	0.1 x10 <sup>3</sup> /uL	
GLUCOSE	105 mg/dL	105 mg/dL
BUN	11 mg/dL	
CREATININE	1.1 mg/dL	1.1 mg/dL
BUN/CREAT RATIO	10.0 Ratio	
Sodium	138 mmol/L	138 mmol/L
POTASSIUM	4.3 mmol/L	4.3 mmol/L
CHLORIDE	101 mmol/L	101 mmol/L
CARBON DIOXIDE	32 mmol/L	
CALCIUM	10.1 mg/dL	10.1 mg/dL
TOTAL PROTEIN	6.9 g/dL	
ALBUMIN	4.4 g/dL	4.4 g/dL
A/G RATIO	1.8 Ratio	1.8 Ratio
ALK. PHOS.	59 U/L	
ALT (SGPT)	14 U/L	

Printed By: Christy Vance

3 of 6

3/24/14 1:05:56 PM

**nComp Visit**

Patient: ARTHUR C. DAVIS  
 Encounter: Mar 6 2014 9:30AM

EMRN: 482122

AST (SGOT)		17 U/L	
TOTAL BILIRUBIN		0.70 mg/dL	
NA		138 mmol/L	
GFR		75.310 CALC	
CHOL/HDL RATIO		4.02	4.02
Potassium			
CHOLESTEROL		177 mg/dL	177 mg/dL
HDL		44 mg/dL	
LDL		105 mg/dL	
TRIGLYCERIDES		141 mg/dL	141 mg/dL
Chloride			
VLDL		28 mg/dL	
Glucose			
Cholesterol			
Triglycerides			
Creatinine			
Chol/HDL Ratio			
Calcium			
Albumin			
AVG Ratio			
TSH		1.04 mIU/ml	
SODIUM	138 mmol/L	138 mmol/L	

**Physical Exam****Constitutional**

General appearance: Well Appearing, Well Developed, In no acute distress; patient was observed to be obese

**Head**

Head: Normocephalic, Atraumatic.

**Eyes**

Pupils and Irlses: equal, round, and reactive to light and accomodation.

**Ears, Nose, Mouth, and Throat**

External inspection of ears and nose: Normal.

Otoscopic examination: External ear canal WNL. TM Not bulging, retracted, or erythematous.

Nasal mucosa, septum, and turbinates: Normal. No discharge.

Lips, teeth, and gums: Normal. Dentition good.

Oropharynx: Palate WNL. Oral Mucosa WNL. Posterior pharynx normal with no signs of post-nasal drip.

**Neck**

Neck: Supple; No swelling or tenderness

Thyroid: No masses palpated. No bruit.

**Pulmonary**

Respiratory effort: Normal. No grunting, splinting, or retracting.

Auscultation of lungs: Normal. No wheezing, rhonchi, or rales.

**Cardiovascular**

Auscultation of heart: Regular rate, & rhythm. No murmur or thrill.

Carotid Arteries: No carotid bruits bilaterally.

Printed By: Christy Vance

4 of 6

3/24/14 1:05:57 PM

**nComp Visit**

Patient: ARTHUR C. DAVIS  
Encounter: Mar 6 2014 9:30AM

EMRN: 482122

Pedal pulses: 2+ bilaterally and symmetric.  
Examination of extremities for edema and/or varicosities: Normal.  
**Abdomen**  
Abdomen: Flat, not distended. Bowel sounds are normal. Soft. Non-tender.  
Examination for hernias: No inguinal or anterior abdominal hernias palpated.  
**Genitourinary**  
Bladder: No tenderness. Normal.  
Scrotal contents: No testicular masses or tenderness. No epididymal masses or tenderness.  
Penis: Normal.  
Digital rectal exam of prostate: Normal. No enlargement or masses palpated  
**Lymphatic**  
Palpation of lymph nodes in neck: Normal.  
**Musculoskeletal**  
Gait and station: Normal.  
Muscle strength/tone: Normal.  
**Neurologic**  
Cranial nerves: II-XII symmetric and within normal limits.  
Reflexes: Deep tendon reflexes 2/4 in the upper and lower extremities bilaterally. Great Toe Extension 5/5.  
Sensation: Normal.  
**Psychiatric**  
Judgment and insight: Normal.  
Orientation to person, place, and time: Normal.  
Recent and remote memory: Normal.  
Mood and affect: Normal.

**Orders**

1. CMP Requested for: 06Sep2014
2. Depression Screening negative. PHQ reviewed (V79.0) Done: 22Mar2014
3. Potassium Chloride ER 10 MEQ Oral Tablet Extended Release; Therapy: 06Aug2013-06Mar2014; Status: DISCONTINUED
4. PSA Requested for: 06Sep2014

**Assessment**

- Health Maintenance V70.0
- Asthma 493.90
- Benign Essential Hypertension 401.1
- Esophageal Reflux 530.81
- Lower Back Pain 724.2

**Discussion/Summary**

Impression: health maintenance visit. Currently, he eats a healthy diet and has an inadequate exercise regimen. Prostate cancer screening: the risks and benefits of prostate cancer screening were discussed, PSA was ordered and PSA testing is needed every year. Testicular cancer screening: the risks and benefits of testicular cancer screening were discussed and clinical testicular exam was done today. Colorectal cancer screening: the risks and benefits of colorectal cancer screening were discussed and colonoscopy has been ordered. The risks and benefits of immunizations were discussed and immunizations are up to date. Advice and education were given regarding nutrition, aerobic exercise, weight bearing exercise, weight loss, helmet use and seat belt use. Patient discussion: discussed with the patient. Follow up in 1 yr with comprehensive labs.

Back pain is persistent and definately disrupting pts life: will refer to SJP for further eval and tx. Cont PT as it is helping.  
(@Results)

**Signatures**

Printed By: Christy Vance

5 of 6

3/24/14 1:05:57 PM



**nComp Visit**

Patient: ARTHUR C. DAVIS  
Encounter: Mar 6 2014 9:30AM

EMRN: 482122

Electronically signed by : NICHOLAS COTE, D.O.; Mar 6 2014 1:10PM (Author)  
Electronically signed by : NICHOLAS COTE, D.O.; Mar 22 2014 1:52PM (Author)

Printed By: Christy Vance

6 of 6

3/24/14 1:05:57 PM



## Fax Message

---

**To:** scanning

**Fax:** 8666671987

**From:** Amor, Maribel

**Date:** 3/21/2014 12:38 PM

**Pages:** 1 of 126 (including this page)

**Subject:** physical therapy notes

---

**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Claim 9452367

*Maribel Amor, MST*  
*Senior Disability Benefit Manager*  
*Aetna Life Insurance Company*  
*Ph: 954-693-2140*  
*Fax: 860-907-4494*  
*E-mail: AmorM@Aetna.com*

Maribel Amor MST  
Senior Disability Benefit Manager  
Aetna Life Insurance Company  
Phone 954-693-2140  
(Fax) 860-907-4494

FROM

(THU)MAR 20 2014 20:41/ST. 20:14/No. 6814013682 P 2



Results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

**Patient:** ARTHUR DAVIS  
**Acct #:** 124961  
**DOB:** REDACTED  
**Physician:** Nicholas Cote MD  
**Phys Fax:** (615) 867-7945  
**Physician:** Not Specified  
**Clinician:** Lakota C. Hillis  
**FSC:** Commercial Insurance  
**Case Mgr:**  
**Payor:** AETNA  
**Pol/Claim#:**

**Visit Date:** Jan 20, 2014  
**Phys Phone:** (615) 867-8010  
**SSN:** XXX-XX-XXXX  
**Inj. Date:** Jan 20, 2014  
**Surg. Date:**  
**Visits:** 1  
**Cxl/Ns:** 0  
**Employer:** DISABILITY  
**Insured:**

## Initial Evaluation

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

Pt reports >20 year history of low back pain which has been self managed with stretches. He reports MVA 9/27/13 in which he was rear ended and has been having increased low back pain since then. Better with supported sitting, position change, worse with sit>stand, gait, laying flat, standing in one place. Pt states he is currently unable to work because of pain.

The patient's medical history has been verbally reviewed with the patient by the evaluating therapist. The medical history questionnaire has been completed and signed by the patient, reviewed by the evaluating therapist, and is on file. The patient has read and signed the Patient Rights and Consent for Treatment forms, they have been reviewed by the evaluating therapist, and are on file.

### Chief Complaint:

- Pain: Current Severity: 8/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 38

## Objective Examination

### Observations:

- Pt able to sit <1 minutes before position changed required secondary to pain. Appearance/Deformity: Pt appears anxious

**Palpation: Lumbosacral Region: Musculature, Posterior:** Left Right

### Guarding:

- |                      |        |        |
|----------------------|--------|--------|
| • Gluteus Maximus    | Severe | Severe |
| • Piriformis         | Severe | Severe |
| • Quadratus Lumborum | Severe | Severe |

### Palpation:

- Pt unable to tolerate >grade 2 palpation secondary to c/o pain.

**Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:**

- |                                 |     |
|---------------------------------|-----|
| • Extension                     | 50% |
| • Flexion(increased pain)       | 75% |
| • Side Bending Left             | 75% |
| • Side Bending Right(most pain) | 75% |

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Electrical Stimulation (unattended)	97014	1	n/a
• Manual Therapy Techniques	97140	1	13
• Physical Therapy Evaluation	97001	1	n/a
• Therapeutic Procedure	97110	1	10

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1(This visit) Did Not Perform: This visit

Document ID: 00700908.001  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 3

FROM

(THU) MAR 20 2014 20:42/ST. 20:14/No. 6814013682 P 3



Patient: ARTHUR DAVIS  
Acct #: 124961

results

Visit Date: Jan 20, 2014

**Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):**

- Closed Kinetic Chain 1 (This visit)

Did Not Perform: This visit

**Manual Interventions: Vertebral Joint Segments:**

- Lumbosacral Spine

Time Elapsed: 8 Minutes, Grade: 1, Body Position: prone pillow under hips, Additional Detail: L 1-5 bilat, Pressure: Oscillatory, Technique 1: Unilateral P-A, Charge As: Manual Therapy Techniques, Billing Code: 97140.

- Vertebral Jt Seg Mobilization 1

Time Elapsed: 5 Minutes, Grade: 1, Body Position: supine, Additional Detail: bilat, Pressure: Oscillatory, Technique 1: light long axis lumbar distraction, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Modalities:**

- Electric Stim, Unattended

Time Elapsed: 12 Minutes, Location: lumbar, Performed With: cryotherapy, Mode: Continuous, Type: Interferential, Clinical Use: Post Activity, Charge As: E-Stim, Unattended, Billing Code: 97014.

**Pt./Family Education:**

- Pathology/Involved Anatomy

Time Elapsed: 10 Minutes, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Timed Code Total Time:**

- 23 Minutes

**Assessment**

Pt present with irritable low back/sacral pain impacting ADL's (working, sitting, standing etc.). Unable to assess joint mobility at time of eval secondary to muscle guarding. Pt would benefit from skilled PT services to address functional return to ADL's.

Treatment Emphasis to focus on: Maximizing function related to:

- ADL's. Work performance.

**Problems & Goals****Problem #1 Chief Complaint: Pain: Current Severity: 8/10.**

LTC Achieve by Feb 17, 2014.

**Symptomatic Improvements:**

- Decreasing Pain: to 3/10.

**Problem #2 Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient.**

LTC Achieve by Feb 17, 2014.

**Questionnaire Improvements: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Follow Up: Patient:**

- Score 50

**Problem #3 Client Knowledge/Awareness of: Home Exercise Program: Lacks appropriate program.**

STC Achieve by Feb 03, 2014.

**Client Education:**

- Independent Home Exercise/Self Care Program.

**Problem #4 Range of Motion: Spine: Pre-Treatment: Active Lumbosacral.**

LTC Achieve by Feb 17, 2014.

**Range of Motion Improvements to: Active Lumbosacral:**

- Gross Assessment WNL

**Problem #5 Palpation: Lumbosacral Region: Musculature, Posterior: Guarding.**

LTC Achieve by Feb 17, 2014. to improve sitting tolerance.

**Palpable Improvements:**

- Guarding Decreasing to: Moderate Levels.

**Problem #6 Observations: Pt able to sit <1 minutes before position changed required secondary to pain.**

Document ID: 0070090B.001  
Lakota C. Hillis, PT (TN Lic: 8886), DPT

Status: Signed off (secure electronic signature)

Page 2 of 3

FROM

(THU)MAR 20 2014 20:42/ST. 20:14/No. 6814013682 P 4



results

**Patient:** ARTHUR DAVIS  
**Acct #:** 124961

**Visit Date:** Jan 20, 2014

*LTG Achieve by Feb 17, 2014. to improve sitting tolerance.*

**Functional Test Improvements:**

- Pt to sit >=10 minutes before needing position change.

## Plan

**Amount, Frequency and Duration:**

- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 3 visits a week with an expected duration of 6 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

**Therapeutic Contents:**

- Client Education, Gait Training, Home Exercise Program, Joint Mobilization Techniques, Manual Therapy Techniques, Modalities: As Needed, Therapeutic Activities, Therapeutic Exercise.
- Additional:
  - Brace/Tape/Splint: Tape, Trigger Point Dry Needling

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Jan 20, 2014 12:35:10

FROM

(THU)MAR 20 2014 20:43/ST. 20:14/No. 6814013682 P 5



Results Physical Therapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

**Patient:** ARTHUR DAVIS  
**Acct #:** 124961  
**DOB:** REDACTED  
**Physician:** Nicholas Cote DO  
**Phys Fax:** (615) 867-7945  
**Physician:** Not Specified  
**Clinician:** Lakota C. Hillis  
**FSC:** Commercial Insurance  
**Case Mgr:**  
**Payor:** AETNA  
**Pol/Claim#:**

**Note Date:** Mar 04, 2014  
**Phys Phone:** (615) 867-8010  
**SSN:** XXX-XX-XXXX  
**Inj. Date:** Jan 20, 2014  
**Surg. Date:**  
**Visits:** 18  
**Cxl/Ns:** 1  
**Employer:** DELL  
**Insured:**

## Progress Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 0/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 48

## Objective Examination

### Observations:

- Pt able to sit 10 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:**

### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

**Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:**

- Extension
- Flexion(increased pain)
- Side Bending Left
- Side Bending Right

**Range of Motion: Spine: Post-Treatment: Active Lumbosacral:**

- Extension
- Flexion

**Left**

Mild  
Mild  
Mild

**Jan 20, 2014**

50%  
75%  
75%  
75%

**Right**

Mild  
Mild  
Mild

**Mar 04, 2014**

100%  
100%  
100%  
100%  
100%

## Assessment

Pt appeared to be progressing well towards goals overall but has started to have high subjective c/o pain. He continues to be able to complete there-ex with correct technique.

## Plan

### Daily Plan:

- Continue w/ Current Rehabilitation Program.



FROM

(THU) MAR 20 2014 20:43/ST. 20:14/No. 6814013682 P 6

Patient: ARTHUR DAVIS  
Acct #: 124961

Note Date: Mar 04, 2014

  
results**Therapy  
Referral**

I have read the above report and request that my patient:

- ☐ Continue with treatment program as indicated above.
- ☐ Continue treatment program for \_\_\_ days/week for \_\_\_ weeks.
- ☐ Revise treatment program as indicated: \_\_\_\_\_
- ☐ Progress to a home exercise program.
- ☐ Be discharged.
- ☐ Other: \_\_\_\_\_

Electronically authenticated.

**Please sign  
and return**Lakota C. Hillis, PT(TN Lic: 8886), DPT  
Signed on Mar 04, 2014 13:19:11

Nicholas Cote DO

Date

FROM

(THU) MAR 20 2014 20:43/ST. 20:14/No. 6814013682 P 7



Results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

**Patient:** ARTHUR DAVIS  
**Acct #:** 124961  
**DOB:** REDACTED  
**Physician:** Nicholas Cote DO  
**Phys Fax:** (615) 867-7945  
**Physician:** Not Specified  
**Clinician:** Lakota C. Hillis  
**FSC:** Commercial Insurance  
**Case Mgr:**  
**Payor:** AETNA  
**Pol/Claim#:**

**Visit Date:** Mar 13, 2014  
**Phys Phone:** (615) 867-8010  
**SSN:** XXX-XX-XXXX  
**Inj. Date:** Jan 20, 2014  
**Surg. Date:**  
**Visits:** 22  
**Cxl/Ns:** 2

**Employer:** DELL  
**Insured:**

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

### Subjective Examination

Pt states he is having a lot of pain still.

#### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 48

### Objective Examination

#### Observations:

- Pt able to sit 15 minutes before position changed required secondary to pain. Gross Movements: Subjective c/o pain higher than objective findings. Pt able to complete all there-ex and there-act with correct technique/no compensations but required 2 attempts for supine to sit transitions with therapist standing next to plinth.

**Palpation: Lumbosacral Region: Musculature, Posterior:**

#### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

**Left**

Mild  
Mild  
Mild

**Right**

Mild  
Mild  
Mild

**Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:**

- Extension 100%
- Flexion(increased pain) 100%
- Side Bending Left 100%
- Side Bending Right 100%

**Range of Motion: Spine: Post-Treatment: Active Lumbosacral:**

- Extension 100%
- Flexion 100%

### Treatments

#### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Therapeutic Activities	97530	2	25
• Therapeutic Procedure	97110	2	20

**Exercise Activities: Machines/Wts.(L. Quarter):**

- Machines/Free Weights 1

Time Elapsed: 20 Minutes, Description: see exercise log, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):**

- Closed Kinetic Chain 1

Time Elapsed: 25 Minutes, Description: see exercise log, Charge As: Therapeutic Activities, Billing Code: 97530.

**Manual Interventions: Vertebral Joint Segments:**

- Lumbosacral Spine(This visit)
- Vertebral Jt Seg Mobilization 1(This visit)

Did Not Perform: This visit  
Did Not Perform: This visit

Document ID: 0070090B.027  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2

FROM

(THU)MAR 20 2014 20:43/ST. 20:14/No. 6814013682 P 8



Patient: ARTHUR DAVIS  
Acct #: 124961

results

Visit Date: Mar 13, 2014

• Vertebral Jt Seg Mobilization 2(This visit)  
**Manual Interventions: Lower Quarter Soft Tissue:**  
• Thoracolumbar PVM(This visit)  
**Manual Interventions: Taping To Stabilize/Align:**  
• Strapping Activity 1(This visit)  
**Modalities:**  
• Electric Stim, Unattended(This visit)  
**Timed Code Total Time:**  
• 45 Minutes

Did Not Perform: This visit

0000000000

Did Not Perform: This visit

0000000000

Did Not Perform: This visit

0000000000

Did Not Perform: This visit

0000000000

## Assessment

Pt able to demonstrate correct technique. High subjective c/o pain.

**Treatment Emphasis to focus on: Maximizing function related to:**

- ADL's. Work performance.

## Plan

### Daily Plan:

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Mar 13, 2014 13:37:01

FROM

(THU) MAR 20 2014 20:43/ST. 20:14/No. 6814013682 P 9



results physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

**Patient:** ARTHUR DAVIS  
**Acct #:** 124961  
**DOB:** REDACTED  
**Physician:** Nicholas Cote DO  
**Phys Fax:** (615) 867-7945  
**Physician:** Not Specified  
**Clinician:** Lakota C. Hillis  
**FSC:** Commercial Insurance  
**Case Mgr:**  
**Payor:** AETNA  
**Pol/Claim#:**

**Visit Date:** Mar 17, 2014  
**Phys Phone:** (615) 867-8010  
**SSN:** XXX-XX-XXXX  
**Inj. Date:** Jan 20, 2014  
**Surg. Date:**  
**Visits:** 23  
**CxI/Ns:** 2  
**Employer:** DELL  
**Insured:**

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

Pt reports "burning sensation" on bottoms of his feet with continued c/o pain in his low back.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 48

## Objective Examination

### Observations:

- Pt able to sit 15 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:**

Left

Right

### Guarding:

- Gluteus Maximus Mild
- Piriformis Mild
- Quadratus Lumborum Mild

Mild  
Mild  
Mild

**Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:**

- Extension 100%
- Flexion(increased pain) 100%
- Side Bending Left 100%
- Side Bending Right 100%

**Range of Motion: Spine: Post-Treatment: Active Lumbosacral:**

- Extension 100%
- Flexion 100%

### Reflex/Sensory Integrity:

- Dermatomal Sensation: Intact and Equal Bilaterally. (Lower Extremity). Neurology intact to strength and sensation testing in bilat LE.

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Therapeutic Activities	97530	2	25
• Therapeutic Procedure	97110	2	20

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1

Time Elapsed: 20 Minutes, Description: see exercise log, Charge As: Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1

Time Elapsed: 25 Minutes, Description: see exercise log, Charge As: Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

- Lumbosacral Spine(This visit)
- Vertebral Jt Seg Mobilization 1(This visit)

Did Not Perform: This visit  
Did Not Perform: This visit

Document ID: 0070090B.028  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2

FROM

(THU)MAR 20 2014 20:43/ST. 20:14/No. 6814013682 P 10

Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Mar 17, 2014

  
results

• Vertebral Jt Seg Mobilization 2(This visit)  
**Manual Interventions: Lower Quarter Soft Tissue:**  
 • Thoracolumbar PVM(This visit)  
**Manual Interventions: Taping To Stabilize/Align:**  
 • Strapping Activity 1(This visit)  
**Modalities:**  
 • Electric Stim, Unattended(This visit)  
**Timed Code Total Time:**  
 • 45 Minutes

Did Not Perform: This visit

Did Not Perform: This visit

Did Not Perform: This visit

Did Not Perform: This visit

## Assessment

Pt with continued high subjective c/o pain but is able to perform all there-ex with correct technique and no substitutions.

## Plan

### Daily Plan:

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
 Signed on Mar 17, 2014 12:09:51

FROM

(THU) MAR 20 2014 20:43/ST. 20:14/No. 6814013682 P 11



results physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

**Patient:** ARTHUR DAVIS  
**Acct#:** 124961  
**DOB:** REDACTED  
**Physician:** Nicholas Cote DO  
**Phys Fax:** (615) 867-7945  
**Physician:** Not Specified  
**Clinician:** Lakota C. Hillis  
**FSC:** Commercial Insurance  
**Case Mgr:**  
**Payor:** AETNA  
**Pol/Claim#:**

**Visit Date:** Mar 18, 2014  
**Phys Phone:** (615) 867-8010  
**SSN:** XXX-XX-XXXX  
**Inj. Date:** Jan 20, 2014  
**Surg. Date:**  
**Visits:** 24  
**Cxl/Ns:** 2

**Employer:** DELL  
**Insured:**

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 48

## Objective Examination

### Observations:

- Pt able to sit 15 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:** Left Right

### Guarding:

• Gluteus Maximus	Mild	Mild
• Piriformis	Mild	Mild
• Quadratus Lumborum	Mild	Mild

### Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

• Extension	100%
• Flexion(increased pain)	100%
• Side Bending Left	100%
• Side Bending Right	100%

### Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

• Extension	100%
• Flexion	100%

### Reflex/Sensory Integrity:

- Neurology intact to strength, reflexes and sensation testing in bilat LE.

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Therapeutic Activities	97530	2	25
• Therapeutic Procedure	97110	2	20

### Exercise Activities: Machines/Wts.(L. Quarter):

• Machines/Free Weights 1 Time Elapsed: 20 Minutes, Description: see exercise log, Charge As: Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

• Closed Kinetic Chain 1 Time Elapsed: 25 Minutes, Description: see exercise log, Charge As: Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

• Lumbosacral Spine(This visit)	Did Not Perform: This visit
• Vertebral Jt Seg Mobilization 1(This visit)	Did Not Perform: This visit
• Vertebral Jt Seg Mobilization 2(This visit)	Did Not Perform: This visit

Document ID: 0070090B.029  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2

FROM

(THU)MAR 20 2014 20:44/ST. 20:14/No. 6814013682 P 12

Patient: ARTHUR DAVIS  
Accl #: 124961

Visit Date: Mar 18, 2014

  
results**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

Did Not Perform: This visit

03/18/2014

**Manual Interventions: Taping To Stabilize/Align:**

- Strapping Activity I(This visit)

Did Not Perform: This visit

03/18/2014

**Modalities:**

- Electric Stim, Unattended(This visit)

Did Not Perform: This visit

03/18/2014

**Timed Code Total Time:**

- 45 Minutes

**Assessment**

Pt at high functional level with no compensations during there-ex but continues to have high subjective c/o pain. Pt appears to be plateauing with therapy. Will likely D/C next visit.

**Plan**

D/C next visit.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Mar 18, 2014 12:40:37

(THU) MAR 20 2014 20:44/ST. 20:14/No. 6814013682 P 13



## Physical Therapy Evaluation & Plan of Care

DATE of EVALUATION: 10-22-13

PATIENT: Arthur C Davis DOB: **REDACTED** STAR account#: 474798  
PHYSICIAN: R James Renfro Jr MD ONSET: 10-11-2013  
DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4 Shoulder  
Pain 719.41 Shoulder Stiffness 719.51  
SURGERY/DATE:

Mr. Davis initiated therapy today with Jason Barclay PT. The results of the evaluation include the following:

**ASSESSMENT/PROBLEM LIST:** Mr. Davis presented today with clinical findings and functional deficits which will be addressed with skilled therapy services. His current therapy problem list includes the following:

- UE weakness
- pain which affects ADLs and IADLs
- decreased ROM
- muscle spasm
- decreased tolerance to sitting
- decreased tolerance to sleeping
- requires home exercise program
- decreased ROM
- altered arthrokinematics
- compensatory movement patterns
- decreased tolerance to household management tasks

### GOALS:

Length	Description
• Short-term	Pt will report less than 3/10 pain in 2 weeks at rest
•	Pt to be instructed in HEP
•	Pt will demonstrate improved postural awareness in 2 weeks evidenced by PT observation of movement patterns in clinic
• Long-term	Pt will improve L shoulder flexion and ER Muscle strength to 4+/5 in 6 weeks
•	Pt will report no more than 2/10 pain at worst in 4 weeks
•	Pt will demonstrate ability to perform all upper body dressing tasks without difficulty or pain in 6 weeks
•	Pt will increase L shoulder AROM to at least 150 degrees of scaption in 6 weeks
•	Pt will be able to perform all normal work related tasks without pain or difficulty in 8 weeks
•	Pt will be able to reach overhead into elevated cabinets without increase in pain in 8 weeks
•	Pt will tolerate at least 30 min continuous sitting activity without increase in low back pain in 6 weeks
•	Pt will report uninterrupted sleep from low back pain in 4 weeks

**PLAN:** We will see Mr. Davis 3 time(s) per week for 6 week(s). Treatment to include modalities PRN, therapeutic exercise, functional activities, neuromuscular re-education, manual therapy, HEP and patient education.

Certification: to

We will keep you informed of his progress.

*Thank you for allowing me to participate in the care of this patient. Please feel free to contact me at the Murfreesboro clinic (615-217-0259) if you have any questions.*

*I certify that my patient requires outpatient rehabilitation services that are reasonable and necessary. I have written and/or reviewed the plan of care.*

Murfreesboro 1725 Medical Center Pkwy, Ste 130 Murfreesboro, TN 37129-2248 Phone: 615-217-0259, FAX: 615-217-1290



FROM

(THU) MAR 20 2014 20:44/ST. 20:14/No. 6814013682 P 14

Patient: Arthur C Davis DOB: REDACTED Date of Evaluation: 10-22-2013 STAR account# 4798 Page 2 of 5

*This note has been electronically signed by  
Jason Barclay PT*

\_\_\_\_\_  
R James Renfro Jr MD

Date: \_\_\_\_\_

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FROM

(THU) MAR 20 2014 20:44/ST. 20:14/No. 6814013682 P 15

Patient: Arthur C Davis DOB: **REDACTED** Date of Evaluation: 10-22-2013 STAR account **474788** Page 3 of 5

**History:** Mr. Davis is a 50 year old male who presents today with the following complaint(s): Tingling and pins and needles into in R leg and sometimes into L leg as well as bilateral shoulder pain. Pt reports right now his back pain is severe and has to "go into weird positions" to get comfortable. Pt reports after being rear ended in an auto accident, his back pain as well as B shoulder pain has worsened. He states his symptoms began several years ago, but pt states resolved until his recent auto accident which re-aggravated his symptoms.. Pt is also post op massive L rotator cuff tear.

Alleviating factors: movement

Brace/Device: L UE sling

Treatment to date: None for his back, Post op L shoulder

Diagnostics: None for back at this time, N/A for shoulder as he is post op

Findings: N/A

**Pain/Symptom Level: 8**

**PMHx/Comorbidities:** His medical history includes but is not limited to asthma and HTN.

Effect(s) of comorbidities/PMHx: potentially delayed healing time

Mr. Davis reports that he is taking the following medications: See list in patient's chart

Past surgical history related to current diagnosis: None /

**Functional Status:** Mr. Davis currently reports that he is functionally limited with respect to his ability to perform sitting more than 10 min, rising, bending, driving, standing nmore than 5 minutes, ascend/descend stairs, sleeping more than 3 hours, reaching overhead, behind the back, across the body and out in front as well as upper body dressing..

Prior to the onset of the current diagnosis, Mr. Davis had no functional limitations.

Occupation/job requirements: Sales/computer

Social history: non-contributory

#### OBJECTIVE TESTS:

Test	Description	Results	Comments
Posture - Trunk / Lower Qtr.	Lordosis	WNL	
Lumbar - Palpation	Lumbar Paraspinals	Severe Muscle Spasm/Guarding R	
	Gluteal Musculature	No Tenderness to Palpation	
	Piriformis	No Tenderness to Palpation	
	Lumbosacral Region	No Tenderness to Palpation	
	Lumbar Spinous Process(es)	No Tenderness to Palpation	
Lumbar - AROM	Flexion	Nil loss	
	Extension	Mod loss	
	Lateral Flexion (R)	Nil loss	
	Lateral Flexion (L)	Nil loss	
	Rotation (R)	Nil loss	
	Rotation (L)	Nil loss	
	Side Gliding (R)	Nil loss	
Lumbar - Neuro Scan - Dermatomes	All Dermatomes (R LE)	intact to light touch, equal B, WNL	
	All Dermatomes (L LE)	intact to light touch, equal B, WNL	
Lumbar - Neuro Scan - Myotomes	Iliopsoas (L1,L2,L3) - R	Normal	
	Quadriceps (L2,L3,L4) - R	Normal	
	Anterior Tibialis (L4) - R	Weak	
	Extensor Hallucis Longus (L5) - R	Normal	
	Gastrocnemius (S1) - R	Normal	
	Peroneus Longus / Brevis (S1) - R	Normal	
	Iliopsoas (L1,L2,L3) - L	Weak/painful	
	Quadriceps (L2,L3,L4) - L	Normal	
	Anterior Tibialis (L4) - L	Normal	

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FROM

(THU) MAR 20 2014 20:44/ST. 20:14/No. 6814013682 P 16

Patient: Arthur C Davis

DOB:

[REDACTED]

Date of Evaluation: 10-22-2013

STAR account #74798

Page 4 of 5

	Extensor Hallucis Longus (L5) - L	Normal	
	Gastrocnemius (S1) - L	Normal	
	Peroneus Longus / Brevis (S1) - L	Normal	
Lumbar - Special Tests	Straight Leg Raise (R)	-	
	Straight Leg Raise (L)	-	
Lower Extremity - Flexibility	LE Flexibility (R)	WNL	
	LE Flexibility (L)	WNL	
General Core Strength	Core Strength	Min. limited	
Shoulder - AROM	Shoulder Flexion (L)		Not tested, PROM only x4 weeks
	Shoulder Abduction (L)		Not tested, PROM only x4 weeks
	Shoulder External Rotation (L)		Not tested, PROM only x4 weeks
	Shoulder Internal Rotation (L)		Not tested, PROM only x4 weeks
	Functional Reach Internal Rotation (L)		Not tested, PROM only x4 weeks
	Functional Reach External Rotation (L)		Not tested, PROM only x4 weeks
Shoulder - PROM	Shoulder Flexion (L)	95 Degrees	
	Shoulder Abduction (L)	60 Degrees	
	Shoulder External Rotation (L)	25 Degrees	
	Shoulder Internal Rotation (L)	40 Degrees	
	Shoulder PROM (L)	Severely limited	

**Additional Comments:** Pt presents with low back pain consistent with muscular origin. No s/s of nerve root involvement at this time. Pt has palpable R sided lumbar paraspinal muscle spasm. Pt is also s/p L shoulder RTC repair PROM for 4 weeks per MD script.

.Pt agrees with goals? \_\_\_\_\_ Yes  
 .Pt agrees with POC? \_\_\_\_\_ Yes  
 .HEP given? \_\_\_\_\_ Yes  
 .Pt aware of Dx/Prognosis? \_\_\_\_\_ Yes

**Prognosis:** Good

**Precautions/Contraindications:** PROM only to L shoulder x 4 weeks

**Therapeutic Procedure/Modality Specifics:**

US for reduction of muscle spasm, E-STIM for reduction of muscle spasm, Vasopneumatic device for the reduction of edema/effusion, Heat and Ice  
 PROM, AROM, AAROM, Strengthening, Stretching and Lumbar/pelvic stabilization  
 ADL modification, Body mechanics education, Diagnosis/anatomy/healing process education, HEP instruction, Plan of care and Posture training/education  
 ADL activities and Reaching activities  
 Myofascial release and Soft tissue/joint mobilization  
 PNF

*Mr. Davis has been advised that compliance with a home program is vital to a successful rehabilitation program. He has been instructed to discontinue any exercise or activity which increases symptoms.*

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3/21/2014 12:38 PM

AETNA -> 18666671987

Page 19 of 126

FROM

(THU)MAR 20 2014 20:44/ST. 20:14/No. 6814013682 P 17

Patient: Arthur C Davis DOB: REDACTED Date of Evaluation: 10-22-2013 STAR accour. 474798 Page 5 of 5

Jason Barclay PT

Murfreesboro 1725 Medical Center Pkwy, Ste 130 Murfreesboro, TN 37129-2248 Phone: 615-217-0259, FAX: 615-217-1290

DCN: 140321068388 PAGE: 037 SEQUENCE: SWF0321201402810001

FROM

(THU) MAR 20 2014 20:45/ST. 20:14/No. 6814013682 P 18

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 10-22-2013

STAR account#: 4.4798

Page 2 of 2

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:** 11:15AM**TIME OUT:** 12:14PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		34
Therapeutic exercise*		10
Functional activities*		5
Manual therapy tech*		
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals	10
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations		
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle		
Pendulums	edu	
SKTC	10" x 5	
DKTC	10" x 5	
LTR	10x each side	
PPT	5" x 5	
*** FUNCTIONAL ACTIVITIES ***		
Pt education	Pt educated on edema management, surgical precautions	
Treadmill - progress to		

**Total Treatment Time:** 59 minutes*This note has been electronically signed by*

Phone: , FAX:



## DAILY TREATMENT NOTE

Date of Note: 10-23-13

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49

Rotator Cuff Tear (traumatic) 840.4

Shoulder Pain 719.41 Shoulder Stiffness 719.51

### Next MD Visit:

**SUBJECTIVE:** Pt reports he felt pretty good after therapy yesterday, until about 2 am when he woke up with back pain and has been in pain ever since. Pt reports his pain at 10/10.

### Pain/Symptom Level:

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Diagnosis/anatomy/healing process education.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt had some increase in pain with DKTC, but overall appears to be tolerating tx well. Added manual techniques for lumbar rotational mobilizations and LE nerve glides as well as PROM to shoulder.

### Current Goals

### Outcome

### New Goals

**PLAN:** Continue with current treatment plan.

This note has been electronically signed by Jason Barclay PT

FROM

(THU) MAR 20 2014 20:45/ST. 20:14/No. 6814013682 P 20

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 10-23-2013

STAR account#: 4, ...98

Page 2 of 2

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:** 10:30AM**TIME OUT:** 11:30AM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		35
Functional activities*		
Manual therapy tech*		25
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	to L shoulder 15 min	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations	10 min including LE nerve glides	
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC	10" x 5 (some pain)	
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
Treadmill - progress to		

**Total Treatment Time:** 60 minutes*This note has been electronically signed by Jason Barclay PT*



## DAILY TREATMENT NOTE

Date of Note: 11-11-13

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49

Rotator Cuff Tear (traumatic) 840.4

Shoulder Pain 719.41 Shoulder Stiffness 719.51

### Next MD Visit:

**SUBJECTIVE:** Pt has seen MD since last visit. Pt presents with new script for PROM only to L shoulder x1 week and diagnosis of lumbar spondylosis in regards to back pain. Pt states he is "just ignoring" his back pain and states he has been out of his sling some including some using the steering wheel.

### Pain/Symptom Level:

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Diagnosis/anatomy/healing process education.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt instructed in lumbar ROM, flexibility and stabilization exercises as well as continued PROM to L shoulder per MD script. Pt reported after treatment that was "the best I've felt in a while leaving therapy"

### Current Goals

### Outcome

### New Goals

**PLAN:** Continue with current treatment plan. PN next visit.

*This note has been electronically signed by Jason Barclay PT*



FROM

(THU) MAR 20 2014 20:45/ST. 20:14/No. 6814013682 P 22

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 11-11-2013

STAR account#: 414798

Page 2 of 2

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:** 10:05AM**TIME OUT:** 11:02AM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		35
Functional activities*		
Manual therapy tech*		20
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations	resume NV	
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC	10" x 5 (some pain)	
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
Treadmill - progress to		

**Total Treatment Time:** 55 minutes*This note has been electronically signed by Jason Barclay PT*

FROM

(THU) MAR 20 2014 20:45/ST. 20:14/No. 6814013682 P 23



## DAILY TREATMENT NOTE

Date of Note: 11-15-13

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

 DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
 Shoulder Pain 719.41 Shoulder Stiffness 719.51

### Next MD Visit:

**SUBJECTIVE:** Pt reports overall decrease in pain and soreness in left shoulder since initial date of therapy. Pt states that his back continues to be increased pain levels and has not changed very much at all. Pt states that he feels like he is getting stronger in his core, but no change in pain or symptoms. Pt reports no significant change in functional status and left shoulder due to surgical precautions. Pt. reports compliance and good tolerance of HEP.

### Pain/Symptom Level:

**OBJECTIVE:** See measurements below. Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: ADL modification, Body mechanics education, Diagnosis/anatomy/healing process education, HEP instruction and Plan of care. Added E-STIM for pain reduction.

Test	Test Description	Current Results	Previous Results	Comments
Posture - Trunk / Lower Qtr.	Lordosis	WNL	WNL	
Lumbar - Palpation	Lumbar Paraspinals			
	Gluteal Musculature			
	Piriformis			
	Lumbosacral Region			
	Lumbar Spinous Process(es)			
Lumbar - AROM	Flexion	Nil loss	Nil loss	
	Extension	Mod loss	Mod loss	
	Lateral Flexion (R)	Nil loss	Nil loss	
	Lateral Flexion (L)	Nil loss	Nil loss	
	Rotation (R)	Nil loss	Nil loss	
	Rotation (L)	Nil loss	Nil loss	
	Side Gliding (R)	Nil loss	Nil loss	
	Side Gliding (L)	Nil loss	Nil loss	
Lumbar - Neuro Scan - Dermatomes	All Dermatomes (R LE)	intact to light touch, equal B, WNL	intact to light touch, equal B, WNL	
	All Dermatomes (L LE)	intact to light touch, equal B, WNL	intact to light touch, equal B, WNL	
Lumbar - Neuro Scan - Myotomes	Iliopsoas (L1,L2,L3) - R		Normal	
	Quadriceps (L2,L3,L4) - R		Normal	
	Anterior Tibialis (L4) - R		Weak	
	Extensor Hallucis Longus (L5) - R		Normal	
	Gastrocnemius (S1) - R		Normal	
	Peroneus Longus / Brevis (S1) - R		Normal	
	Iliopsoas (L1,L2,L3) - L		Weak/painful	
	Quadriceps (L2,L3,L4) - L		Normal	
	Anterior Tibialis (L4) - L		Normal	
	Extensor Hallucis Longus		Normal	

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FROM

(THU)MAR 20 2014 20:45/ST. 20:14/No. 6814013682 P 24

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 11-15-2013

STAR account#: 47.

Page 2 of 4

	(L5) - L			
	Gastrocnemius (S1) - L		Normal	
	Peroneus Longus / Brevis (S1) - L		Normal	
Lumbar - Special Tests	Straight Leg Raise (R)		-	
	Straight Leg Raise (L)		-	
Lower Extremity - Flexibility	LE Flexibility (R)	WNL	WNL	
	LE Flexibility (L)	WNL	WNL	
General Core Strength	Core Strength	Min. limited	Min. limited	
Shoulder - AROM	Shoulder Flexion (L)			NPT due to surgical precautions
	Shoulder Abduction (L)			NPT due to surgical precautions
	Shoulder External Rotation (L)			NPT due to surgical precautions
	Shoulder Internal Rotation (L)			NPT due to surgical precautions
	Functional Reach Internal Rotation (L)			NPT due to surgical precautions
	Functional Reach External Rotation (L)			NPT due to surgical precautions
Shoulder - PROM	Shoulder Flexion (L)	125 Degrees	95 Degrees	
	Shoulder Abduction (L)	80 Degrees	60 Degrees	
	Shoulder External Rotation (L)	40 Degrees	25 Degrees	
	Shoulder Internal Rotation (L)	50 Degrees	40 Degrees	
	Shoulder PROM (L)	Severely limited	Severely limited	

**ASSESSMENT:** Pt tolerated treatment well today. Pt able to continue PROM for left shoulder, demonstrating increase in ROM since initial date of therapy. Pt continues to demonstrate firm and feels and decreased ROM. Pt increasing in core strength, but continues to have increased pain levels in low back. Skilled modality treatment(s) have been utilized for symptom reduction/exercise facilitation/functional improvement as evidenced by: lower pain rating with the use of E-stim for pain reduction.

**Current Goals****Outcome**

Pt will report less than 3/10 pain in 2 weeks at rest	Not Met
Pt to be instructed in HEP	Partially Met
Pt will demonstrate improved postural awareness in 2 weeks evidenced by PT observation of movement patterns in clinic	Partially Met
Pt will improve L shoulder flexion and ER Muscle strength to 4+/5 in 6 weeks	Not Met
Pt will report no more than 2/10 pain at worst in 4 weeks	Not Met
Pt will demonstrate ability to perform all upper body dressing tasks without difficulty or pain in 6 weeks	Not Met
Pt will increase L shoulder AROM to at least 150 degrees of scaption in 6 weeks	Not Met
Pt will be able to perform all normal work related tasks without pain or difficulty in 8 weeks	Not Met
Pt will be able to reach overhead into elevated cabinets without increase in pain in 8 weeks	Not Met
Pt will tolerate at least 30 min continuous sitting activity without increase in low back pain in 6 weeks	Not Met
Pt will report uninterrupted sleep from low back pain in 4 weeks	Partially Met

**New Goals**

--	--

**PLAN:** Pt returning to MD and was given progress report. PN will also be faxed to MD.

This note has been electronically signed by **Kyle Todd PT**

FROM

(THU) MAR 20 2014 20:46/ST. 20:14/No. 6814013682 P 25

Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 11-15-2013

STAR account#: 4. - /98

Page 4 of 4

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks

TIME IN: 07:15AM

TIME OUT: 09:05AM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		35
Functional activities*		
Manual therapy tech*		20
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations	resume NV	
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC	10" x 5 (some pain)	
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
Treadmill - progress to		

Total Treatment Time: minutes

This note has been electronically signed by Kyle Todd PT



## DAILY TREATMENT NOTE

Date of Note: 11-20-13

PATIENT NAME: Arthur C Davis  
PHYSICIAN: R James Renfro Jr MD

PATIENT DOB: REDACTED STAR Account #: 474798

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

### Next MD Visit:

**SUBJECTIVE:** Pt reports being in hospital for past 3 days due to asthma attack. Pt reports shoulder feeling a little more stiff due to not being able to stretch as much. Pt states went to MD and had good report of being on track per protocol and to begin AAROM exercises. Pt reports no change in back pain at all. States nothing seems to make pain better. Pt. reports compliance and good tolerance of HEP.

### Pain/Symptom Level:

**OBJECTIVE:** Progressed treatment to include AAROM pulleys and wall walks. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Body mechanics education, Diagnosis/anatomy/healing process education and HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt able to perform all lumbar/core exercises, but continues to have pain with all exercises and most activity. Pt able to tolerate PROM, but continues to have decreased ROM with firm end feels and appeared to have slight increase in stiffness today.

### Current Goals

### Outcome

### New Goals

**PLAN:** Continue with current treatment plan.

*This note has been electronically signed by Kyle Todd PT*

FROM

(THU) MAR 20 2014 20:46/ST. 20:14/No. 6814013682 P 27

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 11-20-2013

STAR account#: 4.798

Page 2 of 2

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:** 03:00PM**TIME OUT:** 03:45PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		30
Functional activities*		
Manual therapy tech*		20
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations	resume NV if tolerated	
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC	10" x 5 (some pain)	
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
Pulleys	4 min scaption	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
Treadmill - progress to		

**Total Treatment Time:** 50 minutes*This note has been electronically signed by Kyle Todd PT*

(THU) MAR 20 2014 20:46/ST. 20:14/No. 6814013682 P 28



## DAILY TREATMENT NOTE

Date of Note: 11-22-13

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

### Next MD Visit:

**SUBJECTIVE:** Pt reports that back pain has not changed since initiation of therapy. Pt brought in new script for L shoulder-added AAROM and AROM in two weeks. Pt reports shoulder seems to feel a little better since adding AAROM pulleys last visit. Pt reports compliance and good tolerance of HEP. Pt reports no significant change in functional ability since the initiation of therapy.

### Pain/Symptom Level:

**OBJECTIVE:** Progressed treatment to include table slides and scap squeezes. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Body mechanics education, Diagnosis/anatomy/healing process education and HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt able to perform all AAROM exercises, though he has some increase in soreness throughout treatment session. Pt continues to tolerate abd brace and mobility exercises, but has pain throughout lumbar manual and the rex. Pt continues to have moderate tightness in left shoulder with manual therapy and AAROM.

### Current Goals

### Outcome

### New Goals

**PLAN:** Continue per protocol

This note has been electronically signed by Kyle Todd PT

FROM

(THU) MAR 20 2014 20:46/ST. 20:14/No. 6814013682 P 29

Patient: Arthur C Davis

DOB: 1

REDACTED

Date of Note: 11-22-2013

STAR account#: )98

Page 2 of 2

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:** 10:55AM**TIME OUT:** 11:45AM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		30
Functional activities*		
Manual therapy tech*		20
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations	not tolerated well today	
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC	10" x 5 (some pain)	
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
Pulleys	5 min scaption	
Table slides	5 min	
Wall walks	20x	
Scap squeezes	20x	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
Treadmill - progress to		

**Total Treatment Time:** 50 minutes*This note has been electronically signed by Kyle Todd PT*



(THU)MAR 20 2014 20:46/ST. 20:14/No. 6814013682 P 30



## DAILY TREATMENT NOTE

Date of Note: 11-26-13

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 12-13-13

**SUBJECTIVE:** Pt states he feels his arm is improving, but states his back is "very stiff and painful today". Pt states he did his stretches this morning, but his back is still hurting.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Diagnosis/anatomy/healing process education. (DAILY-Modality)

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt instructed in progression of AAROM exercises for L shoulder which he tolerated well. Pt continues to complain of "tailbone pain" and is progressing with core strength and lumbar mobility exercises. (MODALITY-Assess) (GOAL-PROG)

**Current Goals**

**Outcome**

**New Goals**

**PLAN:** Continue progression per protocol/plan of care for dual diagnosis.

*This note has been electronically signed by Jason Barclay PT*

(THU) MAR 20 2014 20:46/ST. 20:14/No. 6814013682 P 31

FROM

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 11-26-2013

STAR account#:

98

Page 2 of 2

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks

TIME IN: 01:04PM

TIME OUT: 02:25PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		50
Functional activities*		8
Manual therapy tech*		20
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations	not tolerated well today	
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC		
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
Pulleys	5 min scaption	
Table slides	5 min	
Wall walks	20x	
Scap squeezes	20x	
Supine Cane flexion	5" x 20	
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
Treadmill - progress to		
SB wall roll ups for reaching simulation		
Table slides for reaching simulation	5 in scaption	

Total Treatment Time: 78 minutes

This note has been electronically signed by Jason Barclay PT



## DAILY TREATMENT NOTE

Date of Note: 11-27-13

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 11-15-13

**SUBJECTIVE:** Pt reports today was the first time he ran up steps in 4 months. Pt reports his back pain he tries to ignore and continues his "yoga" stretches. Pt reports his shoulder "feels good" today. Pt. reports compliance and good tolerance of HEP.

Pain/Symptom Level:

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Diagnosis/anatomy/healing process education.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt continues to progress with shoulder ROM and decreased shoulder pain levels. Pt did report improved tolerance to stairs today and states he has had some mild decrease in back pain.

Current Goals

Outcome

New Goals

**PLAN:** Continue with current treatment plan.

This note has been electronically signed by Jason Barclay PT

FROM

(THU) MAR 20 2014 20:47/ST. 20:14/No. 6814013682 P 33

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 11-27-2013

STAR account#: 795

Page 2 of 2

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:** 01:30PM**TIME OUT:** 02:35PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		39
Functional activities*		8
Manual therapy tech*		18
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	18 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC		
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
Pulleys	5 min scaption	
Table slides	5 min	
Wall walks	20x	
Scap squeezes	20x	
Supine Cane flexion	5" x 20	
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
Treadmill - progress to		
SB wall roll ups for reaching simulation		
Table slides for reaching simulation	5 in scaption	

**Total Treatment Time:** 65 minutesThis note has been electronically signed by **Jason Barclay PT**



## DAILY TREATMENT NOTE

Date of Note: 11-29-13

PATIENT NAME: Arthur C Davis

PATIENT DOB: [REDACTED] STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 11-15-13

**SUBJECTIVE:** Pt states both of his shoulders are pretty sore today, and reports he did a lot of work on the computer yesterday.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Diagnosis/anatomy/healing process education.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt reported feeling much better after treatment today. Pt demonstrates progress towards goals evidenced by decreasing subjective pain levels.

Current Goals	Outcome

New Goals

**PLAN:** Continue progression per protocol and Continue with current treatment plan.

*This note has been electronically signed by Jason Barclay PT*

FROM

(THU) MAR 20 2014 20:47/ST. 20:14/No. 6814013682 P 35

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 11-29-2013

STAR account# 4798

Page 2 of 2

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:** 11:05AM**TIME OUT:** 12:03PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		36
Functional activities*		6
Manual therapy tech*		15
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	15 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC		
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
Pulleys	5 min scaption	
Table slides	5 min	
Wall walks	20x	
Scap squeezes	20x	
Supine Cane flexion	5" x 20	
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
Treadmill - progress to		
SB wall roll ups for reaching simulation		
Table slides for reaching simulation	5 in scaption	

**Total Treatment Time:** 57 minutes*This note has been electronically signed by Jason Barclay PT*



## DAILY TREATMENT NOTE

Date of Note: 12-03-13

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 11-15-13

**SUBJECTIVE:** Pt states there has been no significant change in pain/symptoms since the last visit. States Bil shoulders continue to ache. States LB is doing a little better. States he went to a spin class over the weekend. Pt. reports compliance and good tolerance of HEP.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. Pt received education on the following: HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments
Posture - Trunk / Lower Qtr.	Lumbar Paraspinals			
Lumbar - Palpation	Gluteal Musculature			
	Piriformis			
	Lumbosacral Region			
	Lumbar Spinous Process(es)			
	Flexion			
Lumbar - AROM	Extension			
	Lateral Flexion (R)			
	Lateral Flexion (L)			
	Rotation (R)			
	Rotation (L)			
	Side Gliding (R)			
	Side Gliding (L)			
	All Dermatomes (R LE)			
Lumbar - Neuro Scan - Dermatomes	All Dermatomes (L LE)			
	Iliopsoas (L1,L2,L3) - R			
Lumbar - Neuro Scan - Myotomes	Quadriceps (L2,L3,L4) - R			
	Anterior Tibialis (L4) - R			
	Extensor Hallucis Longus (L5) - R			
	Gastrocnemius (S1) - R			
	Peroneus Longus / Brevis (S1) - R			
	Iliopsoas (L1,L2,L3) - L			
	Quadriceps (L2,L3,L4) - L			
	Anterior Tibialis (L4) - L			
	Extensor Hallucis Longus (L5) - L			
	Gastrocnemius (S1) - L			
	Peroneus Longus / Brevis (S1) - L			
	Straight Leg Raise (R)			
	Straight Leg Raise (L)			
Lumbar - Special	Straight Leg Raise (L)			

Murfreesboro 1725 Medical Center Pkwy, Ste 130 Murfreesboro, TN 37129-2248 Phone: 615-217-0259, FAX: 615-217-1290

FROM

(THU) MAR 20 2014 20:48/ST. 20:14/No. 6814013682 P 37

Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 12-03-2013

STAR account# 4798

Page 2 of 3

Tests	LE Flexibility (R)			
Lower Extremity - Flexibility	LE Flexibility (L)			
	Shoulder Flexion (L)			
General Core Strength	Shoulder Abduction (L)			
Shoulder - AROM	Shoulder External Rotation (L)			
	Shoulder Internal Rotation (L)			
	Functional Reach Internal Rotation (L)			
	Functional Reach External Rotation (L)			
	Shoulder Flexion (L)			
	Shoulder Abduction (L)			
Shoulder - PROM	Shoulder External Rotation (L)			
	Shoulder Internal Rotation (L)			
	Shoulder PROM (L)			

**ASSESSMENT:** Pt tolerated treatment better today. Pt felt he could go higher on the pulleys. States L leg feels stronger than R with doing core strengthening exercises. Pt. is progressing slowly toward achievement of treatment goals.

**Current Goals****Outcome**

Pt will report less than 3/10 pain in 2 weeks at rest	Not Met
Pt to be instructed in HEP	Partially Met
Pt will demonstrate improved postural awareness in 2 weeks evidenced by PT observation of movement patterns in clinic	Partially Met
Pt will improve L shoulder flexion and ER Muscle strength to 4+/5 in 6 weeks	Not Met
Pt will report no more than 2/10 pain at worst in 4 weeks	Not Met
Pt will demonstrate ability to perform all upper body dressing tasks without difficulty or pain in 6 weeks	Not Met
Pt will increase L shoulder AROM to at least 150 degrees of scaption in 6 weeks	Not Met
Pt will be able to perform all normal work related tasks without pain or difficulty in 8 weeks	Not Met
Pt will be able to reach overhead into elevated cabinets without increase in pain in 8 weeks	Not Met
Pt will tolerate at least 30 min continuous sitting activity without increase in low back pain in 6 weeks	Not Met
Pt will report uninterrupted sleep from low back pain in 4 weeks	Partially Met

**New Goals**

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**PLAN:** Continue with current treatment plan.

This note has been electronically signed by Jason Barclay PT Jay Cargile PTA



FROM

(THU)MAR 20 2014 20:48/ST. 20:14/No. 6814013682 P 38

Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 12-03-2013

STAR account# 4798

Page 3 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:****TIME OUT:**

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		36
Functional activities*		6
Manual therapy tech*		15
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	15 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC		
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
Pulleys	5 min scaption	
Table slides	5 min	
Wall walks	20x	
Scap squeezes	20x	
Supine Cane flexion	5" x 20	
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
Treadmill - progress to		
SB wall roll ups for reaching simulation		
Table slides for reaching simulation	5 in scaption	

**Total Treatment Time:** 57 minutesThis note has been electronically signed by Jason Barclay PT Jay Cargile PTA



## DAILY TREATMENT NOTE

Date of Note: 12-05-13

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 11-15-13

**SUBJECTIVE:** Pt states there has been no significant change in pain/symptoms since the last visit. Pt reports compliance and good tolerance of HEP. Pt reports continued difficulty with all movement and activities that require standing. Pt reports back continues to have increased pain levels. Pt reports he tried to sleep in his bed last night, but was unable due to back pain.

Pain/Symptom Level:

**OBJECTIVE:** Progressed treatment to include UBE. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Body mechanics education, Diagnosis/anatomy/healing process education and Surgical precautions.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt continues to increase AAROM and PROM of shoulder. Pt appears to be improved compared to two weeks ago. Pt able to increase ther ex for lumbar, but continues to have increased pain levels with all ther ex and activity.

Current Goals

Outcome

New Goals

**PLAN:** Continue with current treatment plan and protocol.

This note has been electronically signed by Kyle Todd PT

FROM

(THU)MAR 20 2014 20:48/ST. 20:14/No. 6814013682 P 40

Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 12-05-2013

STAR account# 4798

Page 2 of 2

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:** 10:55AM**TIME OUT:** 11:56AM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		34
Functional activities*		11
Manual therapy tech*		15
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	15 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC		
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
Pulleys	5 min scaption	
Table slides	5 min	
Wall walks	20x	
Scap squeezes	20x	
Supine Cane flexion	5" x 20	
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	6 min L1.0	
SB wall roll ups for reaching simulation		
Table slides for reaching simulation	5 in scaption	

**Total Treatment Time:** 60 minutes*This note has been electronically signed by **Kyle Todd PT***

FROM

(THU) MAR 20 2014 20:48/ST. 20:14/No. 6814013682 P 41



## DAILY TREATMENT NOTE

Date of Note: 12-10-13

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

 DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
 Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 11-15-13

**SUBJECTIVE:** Pt complains of increased pain/symptoms since the last visit. States he has been having increased LB spasms since going to spin class. States he hasn't been sleeping well. Pt. reports compliance with HEP, but did not tolerate it well.

Pain/Symptom Level:

**OBJECTIVE:** Continue treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Body mechanics education, Diagnosis/anatomy/healing process educations.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment today but had increased c/o pain with lumbar exercises. Pt needed increased v/c to relax with shoulder PROM today. Pt. is progressing slowly toward achievement of treatment goals.

Current Goals

Outcome

New Goals

**PLAN:** Continue with current treatment plan.

This note has been electronically signed by Jason Barclay PT Jay Cargile PTA

FROM

(THU) MAR 20 2014 20:48/ST. 20:14/No. 6814013682 P 42

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 12-10-2013

STAR account# 4798

Page 2 of 2

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:****TIME OUT:**

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		34
Functional activities*		11
Manual therapy tech*		15
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	15 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC		
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
Pulleys	5 min scaption	
Table slides	5 min	
Wall walks	20x	
Scap squeezes	20x	
Supine Cane flexion	5" x 20	
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	6 min L1.0	
SB wall roll ups for reaching simulation		
Table slides for reaching simulation	5 in scaption	

**Total Treatment Time:** 60 minutes*This note has been electronically signed by Jason Barclay PT Jay Cargile PTA*

FROM

(THU) MAR 20 2014 20:49/ST. 20:14/No. 6814013682 P 43



## DAILY TREATMENT NOTE

Date of Note: 12-12-13

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4

Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 11-15-13

**SUBJECTIVE:** Pt reports to therapy with increased soreness after reporting using arm more than he probably should. Pt states that shoulder seems to be getting better, and that he has less difficulty with upper body dressing and using arm below shoulder height. Pt. reports compliance and good tolerance of HEP. Pt. reports an overall increase in functional ability since the initiation of treatment. Pt states he is able to use arm more than he was able to prior to last few weeks, but continues to have general soreness and cannot use above shoulder height.

Pain/Symptom Level:

**OBJECTIVE:** See measurements below. Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: ADL modification, Diagnosis/anatomy/healing process education, HEP instruction and Surgical precautions.

Test	Test Description	Current Results	Previous Results	Comments
Posture - Trunk / Lower Qtr.	Lordosis	WNL	WNL	
Lumbar - Palpation	Lumbar Paraspinals	Moderate Muscle Spasm/Guarding	Severe Muscle Spasm/Guarding R	
	Gluteal Musculature	No Tenderness to Palpation	No Tenderness to Palpation	
	Piriformis	No Tenderness to Palpation	No Tenderness to Palpation	
	Lumbosacral Region	No Tenderness to Palpation	No Tenderness to Palpation	
	Lumbar Spinous Process(es)	No Tenderness to Palpation	No Tenderness to Palpation	
Lumbar - AROM	Flexion	Nil loss	Nil loss	
	Extension	Mod loss	Mod loss	
	Lateral Flexion (R)	Nil loss	Nil loss	
	Lateral Flexion (L)	Nil loss	Nil loss	
	Rotation (R)	Nil loss	Nil loss	
	Rotation (L)	Nil loss	Nil loss	
	Side Gliding (R)	Nil loss	Nil loss	
Lumbar - Neuro Scan - Dermatomes	All Dermatomes (R LE)		intact to light touch, equal B, WNL	
	All Dermatomes (L LE)		intact to light touch, equal B, WNL	
Lumbar - Neuro Scan - Myotomes	Iliopsoas (L1,L2,L3) - R		Normal	
	Quadriceps (L2,L3,L4) - R		Normal	
	Anterior Tibialis (L4) - R		Weak	
	Extensor Hallucis Longus (L5) - R		Normal	
	Gastrocnemius (S1) - R		Normal	
	Peroneus Longus / Brevis		Normal	

Murfreesboro 1725 Medical Center Pkwy, Ste 130 Murfreesboro, TN 37129-2248 Phone: 615-217-0259, FAX: 615-217-1290

FROM

(THU) MAR 20 2014 20:49/ST. 20:14/No. 6814013682 P 44

Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 12-12-2013

STAR account# 4798

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	(S1) - R			
	Iliopsoas (L1,L2,L3) - L		Weak/painful	
	Quadriceps (L2,L3,L4) - L		Normal	
	Anterior Tibialis (L4) - L		Normal	
	Extensor Hallucis Longus (L5) - L		Normal	
	Gastrocnemius (S1) - L		Normal	
	Peroneus Longus / Brevis (S1) - L		Normal	
Lumbar - Special Tests	Straight Leg Raise (R)		-	
	Straight Leg Raise (L)		-	
Lower Extremity - Flexibility	LE Flexibility (R)	WNL	WNL	
	LE Flexibility (L)	WNL	WNL	
General Core Strength	Core Strength	Min. limited	Min. limited	
Shoulder - AROM	Shoulder Flexion (L)		Not Tested	
	Shoulder Abduction (L)		Not Tested	
	Shoulder External Rotation (L)		Not Tested	
	Shoulder Internal Rotation (L)		Not Tested	
	Functional Reach Internal Rotation (L)	Not Tested	Not Tested	
	Functional Reach External Rotation (L)	Not Tested	Not Tested	
Shoulder - PROM	Shoulder Flexion (L)	127 Degrees	125 Degrees	
	Shoulder Abduction (L)	90 Degrees	80 Degrees	
	Shoulder External Rotation (L)	55 Degrees	40 Degrees	
	Shoulder Internal Rotation (L)	57 Degrees	50 Degrees	
	Shoulder PROM (L)	Severely limited	Severely limited	

**ASSESSMENT:** Pt tolerated treatment well today. Pt continues to have increased pain levels with all lumbar exercises, but has decreased pain in low back with use of heat pack. Pt increasing in PROM of left shoulder, unable to perform certain ther ex due to pain and weakness of right shoulder (non-surgical shoulder with RTC tear). Pt progressing per protocol at this time, with continued pain at all end ranges of motion.

**Current Goals****Outcome**

Pt will report less than 3/10 pain in 2 weeks at rest	Not Met
Pt to be instructed in HEP	Partially Met
Pt will demonstrate improved postural awareness in 2 weeks evidenced by PT observation of movement patterns in clinic	Partially Met
Pt will improve L shoulder flexion and ER Muscle strength to 4+/5 in 6 weeks	Not Met
Pt will report no more than 2/10 pain at worst in 4 weeks	Not Met
Pt will demonstrate ability to perform all upper body dressing tasks without difficulty or pain in 6 weeks	Not Met
Pt will increase L shoulder AROM to at least 150 degrees of scaption in 6 weeks	Not Met
Pt will be able to perform all normal work related tasks without pain or difficulty in 8 weeks	Not Met
Pt will be able to reach overhead into elevated cabinets without increase in pain in 8 weeks	Not Met
Pt will tolerate at least 30 min continuous sitting activity without increase in low back pain in 6 weeks	Not Met
Pt will report uninterrupted sleep from low back pain in 4 weeks	Partially Met

**New Goals**

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**PLAN:** Continue progression per protocol for remaining 5 visits, then recommend 3x/week for 6 more weeks.

FROM

(THU)MAR 20 2014 20:49/ST. 20:14/No. 6814013682 P 45

Patient: Arthur C Davis DOB: REDACTED

Date of Note: 12-12-2013

STAR account# 4798

Page 3 of 4

*This note has been electronically signed by Kyle Todd,PT*

Murfreesboro 1725 Medical Center Pkwy, Ste 130 Murfreesboro, TN 37129-2248 Phone: 615-217-0259, FAX: 615-217-1290



FROM

(THU)MAR 20 2014 20:49/ST. 20:14/No. 6814013682 P 46

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 12-12-2013

STAR account# 4798

Page 4 of 4

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:** 11:00AM**TIME OUT:** 12:00PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		34
Functional activities*		4
Manual therapy tech*		20
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC		
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
Pulleys	5 min scaption	
Table slides	DC for functional table slides	
Wall walks	20x	
Scap squeezes	20x	
Supine Cane flexion	5" x 20	
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
*** FUNCTIONAL ACTIVITIES ***		
Pt education	PT reassessment- 4 min	
UBE	6 min L1.0 - npt	
SB wall roll ups for reaching simulation		
Table slides for reaching simulation	5 in scaption-npt	

**Total Treatment Time:** 58 minutes*This note has been electronically signed by **Kyle Todd PT***



## DAILY TREATMENT NOTE

Date of Note: 12-17-13

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 11-15-13

**SUBJECTIVE:** Pt. states no real changes since last visit in B shoulders and LB. Saw Dr. wants him to continue to progress per protocol. Pt. states his R shoulder just hurts more, it throbs, from using it more d/t L shoulder being sore. Pt. states he is to return to Dr. Jan 9th and schedule R shld surgery for end of Jan. States RTW date is Feb. 1st, but if having second surgery end of Jan, it will take him off from work until April. Pt. states he did try some aerobic steps at home and did ok. Pt. reports compliance with HEP and surgical precautions. Pt. reports an overall increase in functional ability since the initiation of treatment.

Pain/Symptom Level: 5

**OBJECTIVE:** Continued w/ established POC, progressed therex to include stability ex's: supine protraction, supine flexion, s/l ER, prone rowing, and prone ext. Ended Rx w/ manual stretching. Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities, manual techniques and therapeutic exercise. Pt received education on the following: Diagnosis/anatomy/healing process education, HEP instruction, Plan of care, Posture training/education and Surgical precautions.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt. tolerated all progressed ex's well today. No c/o inc. pain throughout session. Same c/o remain and will benefit from progressed stability/strength in L shoulder to help prepare pt. for surgery on R in 4-6 weeks. Pt. is progressing toward achievement of treatment goals as expected.

Current Goals

Outcome

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New Goals

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**PLAN:** Continue with current treatment plan. Progress shld protocol w/ ROM and strengthening as tolerated. Pt. 9.5-10 weeks out from surgery.

This note has been electronically signed by Jason Barclay PT Nichol Robertson PTA

FROM

(THU)MAR 20 2014 20:50/ST. 20:14/No. 6814013682 P 48

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 12-17-2013

STAR account# 4798

Page 2 of 2

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:** 11:00AM**TIME OUT:** 12:00PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		32
Functional activities*		8
Manual therapy tech*		20
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC		
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
Pulleys	5 min scaption	
Table slides	DC for functional table slides	
Wall walks	20x	
Scap squeezes	20x	
Supine Cane flexion	5" x 20	
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
Supine shld protraction	15x	
Supine shld flexion AROM in pain free range	15x	
S/L ER	15x	
Prone rowing	15x	
Prone extension	15x	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min L1 starting session today	
SB wall roll ups for reaching simulation		
Table slides for reaching simulation	5 in scaption-npt	

**Total Treatment Time:** 60 minutesThis note has been electronically signed by **Jason Barclay PT** **Nichol Robertson PTA**



## DAILY TREATMENT NOTE

Date of Note: 12-19-13

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 11-15-13

**SUBJECTIVE:** Pt. states he is hurting today, his R shoulder "feels like crap," and his L shoulder "feels good." Pt. reported he will be seeing his back Dr. this afternoon. Pt. reports compliance with HEP and surgical precautions. Pt. reports an overall increase in functional ability since the initiation of treatment.

### Pain/Symptom Level:

**OBJECTIVE:** Continued w/ established POC today and progressed reps w/ existing ex's today as tolerated. Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities, manual techniques and therapeutic exercise. Pt received education on the following: Diagnosis/anatomy/healing process education, HEP instruction, Posture training/education and Surgical precautions.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt. did have soreness c/o in L shoulder ending Rx today, but denied any modalities. Pt. did well w/ increasing reps and demonstrates motivation toward recovery. Pt. is progressing toward achievement of treatment goals as expected.

### Current Goals

### Outcome

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### New Goals

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**PLAN:** Continue with current treatment plan.

This note has been electronically signed by Jason Barclay PT Nichol Robertson PTA

FROM

(THU) MAR 20 2014 20:50/ST. 20:14/No. 6814013682 P 50

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 12-19-2013

STAR account# 4798

Page 2 of 2

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:** 10:55AM**TIME OUT:** 11:50AM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		32
Functional activities*		8
Manual therapy tech*		15
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC		
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
Pulleys	5 min scaption	
Table slides	DC for functional table slides	
Wall walks	20x	
Scap squeezes	20x	
Supine Cane flexion	5" x 20	
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
Supine shld protraction	15x	
Supine shld flexion AROM in pain free range	15x	
S/L ER	15x	
Prone rowing	15x	
Prone extension	15x	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min L1 starting session today	
SB wall roll ups for reaching simulation		
Table slides for reaching simulation	5 in scaption-npt	

**Total Treatment Time:** 55 minutesThis note has been electronically signed by Jason Barclay PT Nichol Robertson PTA



## DAILY TREATMENT NOTE

Date of Note: 12-24-13

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 11-15-13

**SUBJECTIVE:** Pt reports that back seems to be getting better. Pt states that MD told him that he did have a tear in disk, but that surgery would not be an option at this time. Pt also states that shoulder is progressively getting better. Pt states that he is able to push shoulder during HEP and throughout the day, and that pain/soreness does not remain or increase at night. Pt reports being able to reach behind back without noticing since previous visit. Pt reports compliance and good tolerance of HEP.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Body mechanics education, Diagnosis/anatomy/healing process education and HEP instruction. (DAILY-Modality)

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt continues to tolerate increased ROM in active and passive movements, but continues to demonstrate decreased ROM in all planes with firm end feels at end range. Pt continues to increase lumbar ROM and core strength. Pt progressing per protocol, slower than normal due to size of initial RTC tear and RTC in right shoulder.

**Current Goals**

**Outcome**

**New Goals**

**PLAN:** Continue with current treatment plan.

*This note has been electronically signed by **Kyle Todd PT***

FROM

(THU)MAR 20 2014 20:51/ST. 20:14/No. 6814013682 P 52

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 12-24-2013

STAR account# 4798

Page 2 of 2

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:** 07:30AM**TIME OUT:** 08:36AM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		37
Functional activities*		8
Manual therapy tech*		15
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recurrent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC		
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
Pulleys	5 min scaption	
Table slides	DC for functional table slides	
Wall walks	20x	
Scap squeezes	20x	
Supine Cane flexion	5" x 20	
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
Supine shld protraction	20x	
Supine shld flexion AROM in pain free range	20x	
S/L ER	20x	
Prone rowing	20x	
Prone extension	20x	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min L1 starting session today	
SB wall roll ups for reaching simulation		
Table slides for reaching simulation	5 in scaption-npt	

**Total Treatment Time:** 60 minutesThis note has been electronically signed by **Kyle Todd PT**



## DAILY TREATMENT NOTE

Date of Note: 12-26-13

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 11-15-13

**SUBJECTIVE:** Pt complains of increased pain/symptoms since the last visit. States his LB is more sore today. States he had increased difficulty sleeping last night. Also, states his R UE is more sore today. Pt. reports compliance and good tolerance of HEP.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Body mechanics education, Diagnosis/anatomy/healing process education and HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment but had increased c/o soreness today. Pt. did have c/o soreness in LB and R shoulder today during therapy. Pt tolerated exercises and PROM for L shoulder well.

Current Goals	Outcome

New Goals

**PLAN:** Continue with current treatment plan.

This note has been electronically signed by Jason Barclay PT Jay Cargile PTA



FROM

(THU) MAR 20 2014 20:51/ST. 20:14/No. 6814013682 P 54

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 12-26-2013

STAR account#

4798

Page 2 of 2

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:****TIME OUT:**

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		37
Functional activities*		8
Manual therapy tech*		15
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC		
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
Pulleys	5 min scaption	
Table slides	DC for functional table slides	
Wall walks	20x	
Scap squeezes	20x	
Supine Cane flexion	5" x 20	
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
Supine shld protraction	20x	
Supine shld flexion AROM in pain free range	20x	
S/L ER	20x	
Prone rowing	20x	
Prone extension	20x	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min L1 starting session today	
SB wall roll ups for reaching simulation		
Table slides for reaching simulation	5 in scaption-npt	

**Total Treatment Time:** 60 minutes*This note has been electronically signed by **Jason Barclay PT** **Jay Cargile PTA***



## DAILY TREATMENT NOTE

Date of Note: 12-31-13

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 11-15-13

**SUBJECTIVE:** Pt states that back has been increased in pain for past 3-4 days. Pt reports left arm is getting better, increasing in ROM and decreasing in pain. Pt reports that able to perform more of gym routine for back and aerobic exercise, but continues to have back pain. Pt reports compliance and good tolerance of HEP. Pt reports having very difficult time with sleeping currently due to back pain.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Body mechanics education, Diagnosis/anatomy/healing process education, HEP instruction and Plan of care. Added E-STIM for pain reduction and Heat during manual therapy on shoulder.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt able to tolerate all ther ex and ROM exercises today, but had more difficulty and increased pain levels in back with all therapy. Pt able to have decreased pain levels in back after e-stim and heat were applied during shoulder manual therapy. Pt progressing in ROM of shoulder, but continues to demonstrate decreased range due to increased pain levels.

**Current Goals**

**Outcome**

**New Goals**

**PLAN:** Continue progression per protocol.

*This note has been electronically signed by **Kyle Todd PT***

FROM

(THU)MAR 20 2014 20:51/ST. 20:14/No. 6814013682 P 56

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 12-31-2013

STAR account# 4798

Page 2 of 2

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:****TIME OUT:**

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		30
Functional activities*		8
Manual therapy tech*		15
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	10
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min L shoulder (15 min today)	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC		
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
Pulleys	5 min scaption	
Table slides	DC for functional table slides	
Wall walks	20x	
Scap squeezes	20x	
Supine Cane flexion	5" x 20	
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
Supine shld protraction	20x	
Supine shld flexion AROM in pain free range	20x	
S/L ER	20x	
Prone rowing	20x	
Prone extension	20x	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min L1 starting session today	
SB wall roll ups for reaching simulation		
Table slides for reaching simulation	5 in scaption-npt	

**Total Treatment Time:** 63 minutesThis note has been electronically signed by Kyle Todd PT



## DAILY TREATMENT NOTE

Date of Note: 01-02-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 11-15-13

**SUBJECTIVE:** Pt complains of increased pain/symptoms since the last visit. States his LB is more sore today secondary to sleeping in his bed last night instead of a futon. States he rates LB pain a 10/10. Pt. reports compliance and good tolerance of HEP.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt able to tolerate therapy but c/o increased LB pain with all exercises.. Pt able to tolerate shoulder exercises with minimal c/o soreness. Estim to LB for pain control.

**Current Goals**

**Outcome**

**New Goals**

**PLAN:** Continue with current treatment plan.

*This note has been electronically signed by Jason Barclay PT Jay Cargile PTA*

FROM

(THU) MAR 20 2014 20:52/ST. 20:14/No. 6814013682 P 58

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 01-02-2014

STAR account# 4798

Page 2 of 2

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:****TIME OUT:**

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		30
Functional activities*		8
Manual therapy tech*		15
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	10
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min L shoulder (15 min today)	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	unable to tolerate seated position	
Pendulums		
SKTC	10" x 10 each LE	
DKTC		
LTR	30x side to side	
PPT	5" x 30	
SB press single arm in supine	5" x 30	
SB LE rollouts	with abdominal brace 30x	
Supine hip abduction	one leg at a time RTB 30x each side	
Pulleys	5 min scaption	
Table slides	DC for functional table slides	
Wall walks	20x	
Scap squeezes	20x	
Supine Cane flexion	5" x 20	
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
Supine shld protraction	20x	
Supine shld flexion AROM in pain free range	20x	
S/L ER	20x	
Prone rowing	20x	
Prone extension	20x	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min L1 starting session today	
SB wall roll ups for reaching simulation		
Table slides for reaching simulation	5 in scaption-npt	

**Total Treatment Time:** 63 minutesThis note has been electronically signed by Jason Barclay PT Jay Cargile PTA

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FROM

(THU) MAR 20 2014 20:52/ST. 20:14/No. 6814013682 P 59



## DAILY TREATMENT NOTE

Date of Note: 01-08-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: [REDACTED] STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4

Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 01-09-14

**SUBJECTIVE:** Pt reports "my shoulder hurts, but I know thats expected". Pt states his "throbbing" is around 7/10. Pt states he feels his shoulder is improving in strength. Pt. reports compliance and good tolerance of HEP.

Pain/Symptom Level: 7

**OBJECTIVE:** See Status for updated objective results/measurements. Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Diagnosis/anatomy/healing process education and Plan of care.

Test	Test Description	Current Results	Previous Results	Comments
Posture - Trunk / Lower Qtr.	Lordosis	WNL	WNL	
Lumbar - Palpation	Lumbar Paraspinals		Moderate Muscle Spasm/Guarding	
	Gluteal Musculature	No Tenderness to Palpation	No Tenderness to Palpation	
	Piriformis	No Tenderness to Palpation	No Tenderness to Palpation	
	Lumbosacral Region	No Tenderness to Palpation	No Tenderness to Palpation	
	Lumbar Spinous Process(es)	No Tenderness to Palpation	No Tenderness to Palpation	
Lumbar - AROM	Flexion	Nil loss	Nil loss	
	Extension	Mod loss	Mod loss	
	Lateral Flexion (R)	Nil loss	Nil loss	
	Lateral Flexion (L)	Nil loss	Nil loss	
	Rotation (R)	Nil loss	Nil loss	
	Rotation (L)	Nil loss	Nil loss	
	Side Gliding (R)	Nil loss	Nil loss	
	Side Gliding (L)	Nil loss	Nil loss	
Lumbar - Neuro Scan - Dermatomes	All Dermatomes (R LE)			
	All Dermatomes (L LE)			
Lumbar - Neuro Scan - Myotomes	Iliopsoas (L1,L2,L3) - R			
	Quadriceps (L2,L3,L4) - R			
	Anterior Tibialis (L4) - R			
	Extensor Hallucis Longus (L5) - R			
	Gastrocnemius (S1) - R			
	Peroneus Longus / Brevis (S1) - R			
	Iliopsoas (L1,L2,L3) - L			
	Quadriceps (L2,L3,L4) - L			
	Anterior Tibialis (L4) - L			
	Extensor Hallucis Longus (L5) - L			

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FROM

(THU) MAR 20 2014 20:52/ST. 20:14/No. 6814013682 P 60

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 01-08-2014

STAR account# 4798

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	Gastrocnemius (S1) - L			
	Peroneus Longus / Brevis (S1) - L			
Lumbar - Special Tests	Straight Leg Raise (R)			
	Straight Leg Raise (L)			
Lower Extremity - Flexibility	LE Flexibility (R)			
	LE Flexibility (L)			
General Core Strength	Shoulder Flexion (L)			
Shoulder - AROM	Shoulder Abduction (L)	75 Degrees	Not Tested	
	Functional Reach Internal Rotation (L)	75 Degrees	Not Tested	
	Functional Reach External Rotation (L)	L3	Not Tested	
	Shoulder Flexion (L)	T2 (difficulty)	Not Tested	
Shoulder - PROM	Shoulder Abduction (L)	137 Degrees	127 Degrees	
	Shoulder External Rotation (L)	95 Degrees	90 Degrees	
	Shoulder Internal Rotation (L)	60 Degrees	55 Degrees	
	Shoulder PROM (L)	57 Degrees	57 Degrees	
		Severely limited	Severely limited	

**ASSESSMENT:** Pt tolerated treatment well today. Pt demonstrates gradual improvements in PROM and AROM. However, his AROM remains significantly limited both due to capsular tightness and significant muscle weakness. Pt's chief complaint remains pain and also continues to report back pain. Continued PT remains indicated to progress ROM and strength to allow pt to return to functional reaching based tasks.

**Current Goals****Outcome**

Pt will report less than 3/10 pain in 2 weeks at rest	Not Met
Pt to be instructed in HEP	Partially Met
Pt will demonstrate improved postural awareness in 2 weeks evidenced by PT observation of movement patterns in clinic	Partially Met
Pt will improve L shoulder flexion and ER Muscle strength to 4+/5 in 6 weeks	Not Met
Pt will report no more than 2/10 pain at worst in 4 weeks	Not Met
Pt will demonstrate ability to perform all upper body dressing tasks without difficulty or pain in 6 weeks	Not Met
Pt will increase L shoulder AROM to at least 150 degrees of scaption in 6 weeks	Not Met
Pt will be able to perform all normal work related tasks without pain or difficulty in 8 weeks	Not Met
Pt will be able to reach overhead into elevated cabinets without increase in pain in 8 weeks	Not Met
Pt will tolerate at least 30 min continuous sitting activity without increase in low back pain in 6 weeks	Not Met
Pt will report uninterrupted sleep from low back pain in 4 weeks	Partially Met

**New Goals**

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**PLAN:** Continue with current treatment plan 3 times per week for 4 more weeks with further progression of gentle AROM and strengthening. Please indicate any additional guidelines.

*This note has been electronically signed by Jason Barclay PT*

FROM

(THU) MAR 20 2014 20:53/ST. 20:14/No. 6814013682 P 61

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 01-08-2014

STAR account# 4788

Page 3 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:** 11:03AM**TIME OUT:** 12:04PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		30
Functional activities*		10
Manual therapy tech*		20
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	Resume NV	
DKTC		
LTR	Resume NV	
PPT	Resume NV	
SB press single arm in supine	Resume NV	
SB LE rollouts	Resume NV	
Supine hip abduction	Resume NV	
Pulleys	Resume NV	
Table slides	DC for functional table slides	
Wall walks	D/C for SB wall roll ups	
Scap squeezes	D/C	
Tband Rows/SAP	RTB 3 x 10 each	
Supine Cane flexion		
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
Supine shld protraction (serratus punches)	#3lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	#1lbs 3 x 10	
Prone rowing	#3lbs 3 x 10	
Prone extension	#1lbs 3 x 10	
*** FUNCTIONAL ACTIVITIES ***		
Pt education	PT reassessment 1/8/14	
UBE	8 min L2 starting session today	
SB wall roll ups for reaching simulation	5" holds x10	
Table slides for reaching simulation	5 in scaption-npt	

**Total Treatment Time:** 60 minutes*This note has been electronically signed by **Jason Barclay PT***





## DAILY TREATMENT NOTE

Date of Note: 01-09-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: [REDACTED]

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

### Next MD Visit:

**SUBJECTIVE:** Pt states he remains in significant low back pain, but states the MD is pleased with his progress in regards to his shoulder recovery. Pt. reports compliance and good tolerance of HEP.

### Pain/Symptom Level:

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Diagnosis/anatomy/healing process education.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt arrived 30 min late to scheduled appointment time and therefore exercises regarding lumbar spine were held for performance of shoulder based treatment. Pt. is progressing toward achievement of treatment goals as expected. Pt presents with new script for further therapy and for a TENS unit provision for low back.

### Current Goals

### Outcome

### New Goals

**PLAN:** Continue with current treatment plan. Discuss TENS unit provision.

*This note has been electronically signed by **Jason Barclay PT***

FROM

(THU)MAR 20 2014 20:53/ST. 20:14/No. 6814013682 P 63

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 01-09-2014

STAR account# )4798

Page 2 of 2

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:** 11:30AM**TIME OUT:** 12:20PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		25
Functional activities*		10
Manual therapy tech*		15
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	Resume NV	
DKTC		
LTR	Resume NV	
PPT	Resume NV	
SB press single arm in supine	Resume NV	
SB LE rollouts	Resume NV	
Supine hip abduction	Resume NV	
Pulleys	Resume NV	
Table slides	DC for functional table slides	
Wall walks	D/C for SB wall roll ups	
Scap squeezes	D/C	
Tband Rows/SAP	RTB 3 x 10 each	
Supine Cane flexion		
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
Supine shld protraction (serratus punches)	#3lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	#1lbs 3 x 10	
Prone rowing	#3lbs 3 x 10	
Prone extension	#1lbs 3 x 10	
*** FUNCTIONAL ACTIVITIES ***		
Pt education	PT reassessment 1/8/14	
UBE	8 min L2 starting session today	
SB wall roll ups for reaching simulation	5" holds x10	
Table slides for reaching simulation	5 in scaption-npt	

**Total Treatment Time:** 50 minutes*This note has been electronically signed by **Jason Barclay PT***

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## DAILY TREATMENT NOTE

Date of Note: 01-14-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

### Next MD Visit:

**SUBJECTIVE:** Pt reports an overall decrease in pain/symptoms since the initiation of therapy. States shoulder is getting stronger but is sore today. States he does feel like he is tolerating exercises better. Pt. reports compliance and good tolerance of HEP.

### Pain/Symptom Level:

**OBJECTIVE:** Progressed treatment per activity flowsheet. Added standing flexion. The following procedures were performed at distinctly different time intervals from each other: manual techniques and therapeutic exercise. Pt received education on the following: HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt progressing in ROM of shoulder, but continues to limitations due to soreness and weakness. Pt fatigued easily with standing shoulder flexion. Pt is progressing slowly toward treatment goals.

### Current Goals

### Outcome

### New Goals

**PLAN:** Continue with current treatment plan.

This note has been electronically signed by Jason Barclay PT Jay Cargile PTA

FROM

(THU) MAR 20 2014 20:53/ST. 20:14/No. 6814013682 P 65

Patient: Arthur C Davls

DOB: [REDACTED]

Date of Note: 01-14-2014

STAR account# 4788

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:****TIME OUT:**

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		25
Functional activities*		10
Manual therapy tech*		15
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	Resume NV	
DKTC		
LTR	Resume NV	
PPT	Resume NV	
SB press single arm in supine	Resume NV	
SB LE rollouts	Resume NV	
Supine hip abduction	Resume NV	
Pulleys	5 min	
Table slides	DC for functional table slides	
Wall walks	D/C for SB wall roll ups	
Scap squeezes	D/C	
Tband Rows/SAP	RTB 3 x 10 each	
Supine Cane flexion		
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
Supine shld protraction (serratus punches)	#3lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	#1lbs 3 x 10	
Prone rowing	#3lbs 3 x 10	
Prone extension	#1lbs 3 x 10	
standing flexion	x10 fatigued easily	
*** FUNCTIONAL ACTIVITIES ***		
Pt education	PT reassessment 1/8/14	
UBE	8 min L2 starting session today	
SB wall roll ups for reaching simulation	5" holds x10	
Table slides for reaching simulation	5 in scaption-npt	

**Total Treatment Time:** 50 minutesThis note has been electronically signed by Jason Barclay PT Jay Cargile PTA

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## DAILY TREATMENT NOTE

Date of Note: 01-16-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 01-31-14

**SUBJECTIVE:** Pt states he has seen a pain specialist for his back this morning who was concerned with how "hypersensitive" his back was. Pt states he feels his shoulder is continuing to improve.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Diagnosis/anatomy/healing process education and HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt progressed with further RTC strengthening and continues to progress as expected. Pt remains limited in AROM to all planes, which is gradually improving. Pt tolerates pROM well.

**Current Goals**

**Outcome**

**New Goals**

**PLAN:** Continue with current treatment plan.

*This note has been electronically signed by **Jason Barclay PT***

FROM

(THU) MAR 20 2014 20:54/ST. 20:14/No. 6814013682 P 67

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 01-16-2014

STAR account# 4798

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:** 11:00AM**TIME OUT:** 12:16PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		38
Functional activities*		12
Manual therapy tech*		20
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	Resume NV	
DKTC		
LTR	Resume NV	
PPT	Resume NV	
SB press single arm in supine	Resume NV	
SB LE rollouts	Resume NV	
Supine hip abduction	Resume NV	
Pulleys	5 min	
Table slides	DC for functional table slides	
Wall walks	D/C for SB wall roll ups	
Scap squeezes	D/C	
Tband Rows/SAP	GTB 3 x 10 each	
Tband ER	RTB 3 x 15 each	
Tband IR	RTB 3 x 15 each	
Supine Cane flexion		
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
Supine shld protraction (serratus punches)	#3lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	#1lbs 3 x 10	
Prone rowing	#3lbs 3 x 10	
Prone extension	#1lbs 3 x 10	
standing flexion	2 x10 fatigued easily	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min L2 starting session today	
SB wall roll ups for reaching simulation	5" holds x10	
Table slides for reaching simulation	5 in scaption-npt	
Wall Washes	10x	

**Total Treatment Time:** 70 minutes

Murfreesboro 1725 Medical Center Pkwy, Ste 130 Murfreesboro, TN 37129-2248 Phone: 615-217-0259, FAX: 615-217-1290

FROM

(THU)MAR 20 2014 20:54/ST. 20:14/No. 6814013682 P 68

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 01-16-2014

STAR account# 4798

Page 3 of 3

*This note has been electronically signed by Jason Barclay PT*

Murfreesboro 1725 Medical Center Pkwy, Ste 130 Murfreesboro, TN 37129-2248 Phone: 615-217-0259, FAX: 615-217-1290



## DAILY TREATMENT NOTE

Date of Note: 01-21-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 01-31-14

**SUBJECTIVE:** Pt states there has been no significant change in pain/symptoms since the last visit. Pt. reports compliance and good tolerance of HEP. Pt reports having increase in ROM and function since initiation of therapy. Pt reports still having difficulty with activities that require heavy lifting due to lifting precautions and decreased strength.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Body mechanics education, Diagnosis/anatomy/healing process education and HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt increasing in ROM in all planes, still limited in flexion and especially in abduction. Pt. is progressing toward achievement of treatment goals as expected.

**Current Goals**

**Outcome**

**New Goals**

**PLAN:** Continue progression per protocol.

*This note has been electronically signed by Kyle Todd PT*



FROM

(THU)MAR 20 2014 20:54/ST. 20:14/No. 6814013682 P 70

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 01-21-2014

STAR account# 4798

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:****TIME OUT:**

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		35
Functional activities*		12
Manual therapy tech*		25
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	25 min to L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	Resume NV	
DKTC		
LTR	Resume NV	
PPT	Resume NV	
SB press single arm in supine	Resume NV	
SB LE rollouts	Resume NV	
Supine hip abduction	Resume NV	
Pulleys	5 min	
Table slides	DC for functional table slides	
Wall walks	D/C for SB wall roll ups	
Scap squeezes	D/C	
Tband Rows/SAP	GTB 3 x 10 each	
Tband ER	RTB 3 x 15 each	
Tband IR	RTB 3 x 15 each	
Supine Cane flexion		
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
Supine shld protraction (serratus punches)	#3lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	#1lbs 3 x 10	
Prone rowing	#3lbs 3 x 10	
Prone extension	#1lbs 3 x 10	
standing flexion	2 x10 fatigued easily	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min L2 starting session today	
SB wall roll ups for reaching simulation	5" holds x10	
Table slides for reaching simulation	5 in scaption-npt	
Wall Washes	10x	

**Total Treatment Time:** 72 minutes

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3/21/2014 12:38 PM

AETNA -> 18666671987

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FROM

(THU)MAR 20 2014 20:54/ST. 20:14/No. 6814013682 P 71

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 01-21-2014

STAR account# 4798

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DCN: 140321068388 PAGE: 145 SEQUENCE: SWF0321201402810001

Case 1:15-cv-00086 Document 13-1 Filed 02/18/16 Page 590 of 1151 Page ID #: 634

FROM

(THU) MAR 20 2014 20:54/ST. 20:14/No. 6814013682 P 72



## DAILY TREATMENT NOTE

Date of Note: 01-23-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

 DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
 Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 01-31-14

**SUBJECTIVE:** Pt reports an overall decrease in pain/symptoms since the initiation of therapy. States he has been pushing his L shoulder harder. States he has improved with putting his hand behind his head. Pt. reports compliance and good tolerance of HEP.

Pain/Symptom Level:

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Body mechanics education, Diagnosis/anatomy/healing process education and HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt progressing well with ROM. Pt also progressing well with strengthening exercises. Pt. is progressing toward achievement of treatment goals as expected.

Current Goals

Outcome

--	--

New Goals

--	--

**PLAN:** Continue with current treatment plan.

This note has been electronically signed by Kyle Todd PT Jay Cargile PTA

FROM

(THU)MAR 20 2014 20:54/ST. 20:14/No. 6814013682 P 73

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 01-23-2014

STAR account# 4798

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:****TIME OUT:**

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		35
Functional activities*		12
Manual therapy tech*		15
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	15 min to L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	Resume NV	
DKTC		
LTR	Resume NV	
PPT	Resume NV	
SB press single arm in supine	Resume NV	
SB LE rollouts	Resume NV	
Supine hip abduction	Resume NV	
Pulleys	5 min	
Table slides	DC for functional table slides	
Wall walks	D/C for SB wall roll ups	
Scap squeezes	D/C	
Tband Rows/SAP	GTB 3 x 10 each	
Tband ER	RTB 3 x 15 each	
Tband IR	RTB 3 x 15 each	
Supine Cane flexion		
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
Supine shld protraction (serratus punches)	#3lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	#1lbs 3 x 10	
Prone rowing	#3lbs 3 x 10	
Prone extension	#1lbs 3 x 10	
standing flexion	2 x10 fatigued easily	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	10 min L2 starting session today	
SB wall roll ups for reaching simulation	5" holds x10	
Table slides for reaching simulation	5 in scaption-npt	
Wall Washes	10x	

**Total Treatment Time:** 62 minutes

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FROM

(THU)MAR 20 2014 20:55/ST. 20:14/No. 6814013682 P 74

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 01-23-2014

STAR account# 4798

Page 3 of 3

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## DAILY TREATMENT NOTE

Date of Note: 01-27-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4

Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 01-31-14

**SUBJECTIVE:** Pt states there has been no significant change in pain/symptoms since the last visit. Pt. reports compliance and good tolerance of HEP. Pt. reports an overall increase in functional ability since the initiation of treatment. Pt reports reaching and lifting activities appear to be getting easier, but concerned with ADL's due to having RTC repair on opposite shoulder this Friday.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and mechanical traction. Pt received education on the following: Body mechanics education, Diagnosis/anatomy/healing process education and HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt increasing in AROM and PROM, but continues to be limited in ROM. Pt demonstrated firm end feel with pain in flexion/scaption/abduction/ER. Pt able to demonstrate good IR PROM. Pt able to increase weights without increase in pain. Pt. is progressing toward achievement of treatment goals as expected.

**Current Goals**

**Outcome**

**New Goals**

**PLAN:** Continue with current treatment plan.

*This note has been electronically signed by **Kyle Todd PT***

FROM

(THU) MAR 20 2014 20:55/ST. 20:14/No. 6814013682 P 76

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 01-27-2014

STAR account# 4798

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks

TIME IN:

TIME OUT:

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		35
Functional activities*		12
Manual therapy tech*		15
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	15 min to L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	Resume NV	
DKTC		
LTR	Resume NV	
PPT	Resume NV	
SB press single arm in supine	Resume NV	
SB LE rollouts	Resume NV	
Supine hip abduction	Resume NV	
Pulleys	5 min	
Table slides	DC for functional table slides	
Wall walks	D/C for SB wall roll ups	
Scap squeezes	D/C	
Tband Rows/SAP	GTB 3 x 10 each	
Tband ER	RTB 3 x 15 each	
Tband IR	RTB 3 x 15 each	
Supine Cane flexion		
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	RTB 30x each side	
Supine shld protraction (serratus punches)	#3lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	#1lbs 3 x 10	
Prone rowing	#3lbs 3 x 10	
Prone extension	#1lbs 3 x 10	
standing flexion	2 x10 fatigued easily	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	10 min L2 starting session today	
SB wall roll ups for reaching simulation	5" holds x10	
Table slides for reaching simulation	5 in scaption-npt	
Wall Washes	10x	

Total Treatment Time: minutes

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FROM

(THU) MAR 20 2014 20:55/ST. 20:14/No. 6814013682 P 77

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 01-27-2014

STAR account# 4798

Page 3 of 3

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## DAILY TREATMENT NOTE

Date of Note: 01-30-14

**PATIENT NAME:** Arthur C Davis

**PATIENT DOB:** REDACTED **STAR Account #:** 474798

**PHYSICIAN:** R James Renfro Jr MD

**DIAGNOSIS:** Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

**Next MD Visit:** 01-31-14

**SUBJECTIVE:** Pt reports shoulder continues to improve in ROM, strength, and decreasing in pain with activity. Pt reports compliance and good tolerance of HEP. Pt states having improved tolerance to over shoulder height activity since previous visit.

**Pain/Symptom Level:**

**OBJECTIVE:** See measurements below. Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: ADL modification, Body mechanics education, Diagnosis/anatomy/healing process education and HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments
Posture - Trunk / Lower Qtr.	Lordosis	WNL	WNL	
Lumbar - Palpation	Lumbar Paraspinals		Moderate Muscle Spasm/Guarding	
	Gluteal Musculature		No Tenderness to Palpation	
	Piriformis		No Tenderness to Palpation	
	Lumbosacral Region		No Tenderness to Palpation	
	Lumbar Spinous Process(es)		No Tenderness to Palpation	
Lumbar - AROM	Flexion		Nil loss	
	Extension		Mod loss	
	Lateral Flexion (R)		Nil loss	
	Lateral Flexion (L)		Nil loss	
	Rotation (R)		Nil loss	
	Rotation (L)		Nil loss	
	Side Gliding (R)		Nil loss	
	Side Gliding (L)		Nil loss	
Lumbar - Neuro Scan - Dermatomes	All Dermatomes (R LE)		intact to light touch, equal B, WNL	
	All Dermatomes (L LE)		intact to light touch, equal B, WNL	
Lumbar - Neuro Scan - Myotomes	Iliopsoas (L1,L2,L3) - R		Normal	
	Quadriceps (L2,L3,L4) - R		Normal	
	Anterior Tibialis (L4) - R		Weak	
	Extensor Hallucis Longus (L5) - R		Normal	
	Gastrocnemius (S1) - R		Normal	
	Peroneus Longus / Brevis (S1) - R		Normal	
	Iliopsoas (L1,L2,L3) - L		Weak/painful	

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FROM

(THU)MAR 20 2014 20:55/ST. 20:14/No. 6814013682 P 79

Patient: Arthur C Davis

DOB:

[REDACTED]

Date of Note: 01-30-2014

STAR account#

4798

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	Quadriceps (L2,L3,L4) - L		Normal	
	Anterior Tibialis (L4) - L		Normal	
	Extensor Hallucis Longus (L5) - L		Normal	
	Gastrocnemius (S1) - L		Normal	
	Peroneus Longus / Brevis (S1) - L		Normal	
Lumbar - Special Tests	Straight Leg Raise (R)		-	
	Straight Leg Raise (L)		-	
Lower Extremity - Flexibility	LE Flexibility (R)		WNL	
	LE Flexibility (L)		WNL	
General Core Strength	Shoulder Flexion (L)		Min. limited	
Shoulder - AROM	Shoulder Abduction (L)	135 Degrees	75 Degrees	
	Functional Reach Internal Rotation (L)	95 Degrees	75 Degrees	
	Functional Reach External Rotation (L)	L3	L3	
	Shoulder Flexion (L)	T4	T2 (difficulty)	
Shoulder - PROM	Shoulder Abduction (L)	160 Degrees	137 Degrees	
	Shoulder External Rotation (L)	140 Degrees	95 Degrees	
	Shoulder Internal Rotation (L)	80 Degrees	60 Degrees	
	Shoulder PROM (L)	60 Degrees	57 Degrees	
		Min. limited	Severely limited	

**ASSESSMENT:** Pt tolerated treatment well today. Pt able to perform all ther ex increased ROM and strength as seen through progression of weights and resistance. Pt continues to have decreased PROM and AROM, but much improved since last 2 visits in PROM. Pt. is progressing toward achievement of treatment goals as expected.

**Current Goals****Outcome**

Pt will report less than 3/10 pain in 2 weeks at rest	Partially Met
Pt to be instructed in HEP	Met
Pt will demonstrate improved postural awareness in 2 weeks evidenced by PT observation of movement patterns in clinic	Met
Pt will improve L shoulder flexion and ER Muscle strength to 4+/5 in 6 weeks	Partially Met
Pt will report no more than 2/10 pain at worst in 4 weeks	Partially Met
Pt will demonstrate ability to perform all upper body dressing tasks without difficulty or pain in 6 weeks	Met
Pt will increase L shoulder AROM to at least 150 degrees of scaption in 6 weeks	Not Met
Pt will be able to perform all normal work related tasks without pain or difficulty in 8 weeks	Not Met
Pt will be able to reach overhead into elevated cabinets without increase in pain in 8 weeks	Partially Met
Pt will tolerate at least 30 min continuous sitting activity without increase in low back pain in 6 weeks	Not Met
Pt will report uninterrupted sleep from low back pain in 4 weeks	Partially Met

**New Goals**

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**PLAN:** Continue with current treatment plan, pt returns to MD for RTC repair of right shoulder 1/31/2014. Pt to return next week to continue therapy per MD orders.

This note has been electronically signed by **Kyle Todd PT**

FROM

(THU) MAR 20 2014 20:56/ST. 20:14/No. 6814013682 P 80

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 01-30-2014

STAR account# 4798

Page 3 of 4

**PRECAUTIONS/CONTRAINDICATIONS:** PROM only to L shoulder x 4 weeks**TIME IN:****TIME OUT:**

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		36
Functional activities*		12
Manual therapy tech*		15
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	15 min to L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	20x	
DKTC		
LTR	20x	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	5 min	
Table slides	DC for functional table slides	
Wall walks	D/C for SB wall roll ups	
Scap squeezes	D/C	
Tband Rows/SAP	BTB 3 x 10 each	
Tband ER	BTB 3 x 15 each	
Tband IR	BTB 3 x 15 each	
Supine Cane flexion		
Standing Cane flexion	5" x 20	
Standing Cane ER for AAROM	5" x 20	
Seated SB marching/LAQ	30x each	
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#3lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	#1lbs 3 x 10	
Prone rowing	#3lbs 3 x 10	
Prone extension	#1lbs 3 x 10	
standing flexion	2 x10 fatigued easily	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	11 min L2.5 starting session today	
SB wall roll ups for reaching simulation	5" holds x10	
Table slides for reaching simulation	5 in scaption-npt	
Wall Washes	10x	

**Total Treatment Time:** 63 minutes

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FROM

(THU)MAR 20 2014 20:56/ST. 20:14/No. 6814013682 P 81

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 01-30-2014

STAR account# 4798

Page 4 of 4

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## DAILY TREATMENT NOTE

Date of Note: 02-07-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 01-31-14

**SUBJECTIVE:** Pt returns to therapy post-op RTC repair on right shoulder. Pt has not been released for therapy on RUE, only to have therapy on LUE. Pt reports compliance and good tolerance of HEP. Pt reports having to use LUE more often due to new surgery on RUE. Pt states reaching, lifting, and overhead/behind the back activities continue to be most difficult.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. Held on the ex or functional activities that required S/L, prone, or BUE. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: ADL modification, Body mechanics education, Diagnosis/anatomy/healing process education and HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt able to tolerate increased manual therapy. Pt continues to fatigue quickly with elevation activities. Pt is progressing toward achievement of treatment goals as expected.

**Current Goals**

**Outcome**

**New Goals**

**PLAN:** Continue progression per protocol, holding on RUE PROM until released for PT.

*This note has been electronically signed by Kyle Todd PT*

FROM

(THU) MAR 20 2014 20:56/ST. 20:14/No. 6814013682 P 83

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 02-07-2014

STAR account# 4788

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues to be on hold for PT**TIME IN:****TIME OUT:**

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		20
Functional activities*		10
Manual therapy tech*		30
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	15 min to L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each	
Tband IR	BTB 3 x 15 each	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#3lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	HOLD- may attempt LLE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	
Table slides ER	5 min	

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FROM

(THU)MAR 20 2014 20:57/ST. 20:14/No. 6814013682 P 84

Patient: Arthur C Davis DOB: REDACTED Date of Note: 02-07-2014 STAR account# 4798 Page 3 of 3

Total Treatment Time: 60 minutes

This note has been electronically signed by Kyle Todd PT

FROM

(THU) MAR 20 2014 20:57/ST. 20:14/No. 6814013682 P 85



## DAILY TREATMENT NOTE

Date of Note: 02-11-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4

Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 01-31-14

**SUBJECTIVE:** Pt states feeling like he may have lost some motion in LUE since having to take 1 week off due to post-surgery on RUE. Pt. reports compliance and good tolerance of HEP. Pt states that bathing, grooming, and upper body is difficult due to tightness and decreased use of RUE per surgical precautions. Pt reports that overhead reaching continues to be moderately difficult due to weakness and tightness, appearing to "lock up" around shoulder height.

Pain/Symptom Level:

**OBJECTIVE:** See measurements below. Progressed treatment per activity flowsheet. Held on ther ex and activities that required prone lying or RUE use today due to RUE surgical precautions. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: ADL modification, Body mechanics education and HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments
Posture - Trunk / Lower Qtr.	Lordosis	WNL	WNL	
Lumbar - Palpation	Lumbar Paraspinals		Moderate Muscle Spasm/Guarding	
	Gluteal Musculature		No Tenderness to Palpation	
	Piriformis		No Tenderness to Palpation	
	Lumbosacral Region		No Tenderness to Palpation	
	Lumbar Spinous Process(es)		No Tenderness to Palpation	
Lumbar - AROM	Flexion		Nil loss	
	Extension		Mod loss	
	Lateral Flexion (R)		Nil loss	
	Lateral Flexion (L)		Nil loss	
	Rotation (R)		Nil loss	
	Rotation (L)		Nil loss	
	Side Gliding (R)		Nil loss	
Lumbar - Neuro Scan - Dermatomes	Side Gliding (L)		Nil loss	
	All Dermatomes (R LE)		intact to light touch, equal B, WNL	
Lumbar - Neuro Scan - Myotomes	All Dermatomes (L LE)		intact to light touch, equal B, WNL	
	Iliopsoas (L1,L2,L3) - R		Normal	
	Quadriceps (L2,L3,L4) - R		Normal	
	Anterior Tibialis (L4) - R		Weak	
	Extensor Hallucis Longus (L5) - R		Normal	
	Gastrocnemius (S1) - R		Normal	
	Peroneus Longus / Brevis (S1) - R		Normal	

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FROM

(THU) MAR 20 2014 20:57/ST. 20:14/No. 6814013682 P 86

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 02-11-2014

STAR account# 4798

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	Iliopsoas (L1,L2,L3) - L		Weak/painful	
	Quadriceps (L2,L3,L4) - L		Normal	
	Anterior Tibialis (L4) - L		Normal	
	Extensor Hallucis Longus (L5) - L		Normal	
	Gastrocnemius (S1) - L		Normal	
	Peroneus Longus / Brevis (S1) - L		Normal	
Lumbar - Special Tests	Straight Leg Raise (R)		-	
	Straight Leg Raise (L)		-	
Lower Extremity - Flexibility	LE Flexibility (R)		WNL	
	LE Flexibility (L)		WNL	
General Core Strength	Shoulder Flexion (L)		Min. limited	
Shoulder - AROM	Shoulder Abduction (L)	140 Degrees	135 Degrees	
	Functional Reach Internal Rotation (L)	95 Degrees	95 Degrees	
	Functional Reach External Rotation (L)	T10	L3	
	Shoulder Scaption with Functional ER	T6	T4	
	Shoulder Flexion (L)	145 Degrees		
	Shoulder Abduction (L)	180 Degrees	160 Degrees	
Shoulder - PROM	Shoulder External Rotation (L)	140 Degrees	140 Degrees	
	Shoulder Internal Rotation (L)	80 Degrees	80 Degrees	
	Shoulder PROM (L)	60 Degrees	60 Degrees	
		Min. limited	Min. limited	

**ASSESSMENT:** Pt tolerated treatment well today. Pt continues to increase in PROM, but continues to be limited in AROM due to weakness and continued functional tightness. Pt continues to demonstrate weakness in all planes of motion, limiting functional activities at home. Pt will continue to benefit from skilled PT to increase ROM of LUE as well as strength in shoulder height and overhead activities.

**Current Goals****Outcome**

Pt will report less than 3/10 pain in 2 weeks at rest	Partially Met
Pt to be instructed in HEP	Met
Pt will demonstrate improved postural awareness in 2 weeks evidenced by PT observation of movement patterns in clinic	Met
Pt will improve L shoulder flexion and ER Muscle strength to 4+/5 in 6 weeks	Partially Met
Pt will report no more than 2/10 pain at worst in 4 weeks	Partially Met
Pt will demonstrate ability to perform all upper body dressing tasks without difficulty or pain in 6 weeks	Met
Pt will increase L shoulder AROM to at least 150 degrees of scaption in 6 weeks	Not Met
Pt will be able to perform all normal work related tasks without pain or difficulty in 8 weeks	Not Met
Pt will be able to reach overhead into elevated cabinets without increase in pain in 8 weeks	Partially Met
Pt will tolerate at least 30 min continuous sitting activity without increase in low back pain in 6 weeks	Not Met
Pt will report uninterrupted sleep from low back pain in 4 weeks	Partially Met

**New Goals**

--	--

**PLAN:** Pt returns to MD this afternoon, Progress report given to patient and faxed to MD. Continue per protocol, increasing ROM and strength for remaining 3 visits, then continue per MD recommendations for LUE and for future RUE visits.

This note has been electronically signed by **Kyle Todd PT**

Murfreesboro 1725 Medical Center Pkwy, Ste 130 Murfreesboro, TN 37129-2248 Phone: 615-217-0259, FAX: 615-217-1290

FROM

(THU)MAR 20 2014 20:57/ST. 20:14/No. 6814013682 P 87

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 02-11-2014

STAR account# 4798

Page 4 of 5

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues to be on hold for PT**TIME IN:****TIME OUT:**

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		22
Functional activities*		10
Manual therapy tech*		30
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	15 min to L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each	
Tband IR	BTB 3 x 15 each	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#3lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x 10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #10	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	HOLD- may attempt LLE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	
Table slides ER	5 min	

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FROM

(THU) MAR 20 2014 20:58/ST. 20:14/No. 6814013682 P 88

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 02-11-2014

STAR account# 4798

Page 5 of 5

**Total Treatment Time: 62 minutes**

*This note has been electronically signed by Kyle Todd PT*



## DAILY TREATMENT NOTE

Date of Note: 02-13-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: [REDACTED]

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4

Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 01-31-14

**SUBJECTIVE:** Pt reports returned to MD yesterday and check up on RUE. Pt reports was not given new script for PT and not sure about continuing therapy. Pt states left shoulder "feels locked". Pt reports before surgery on RUE appeared to have good ROM and better strength, leading to increased function with LUE grooming, dressing, and bathing. Pt states all overhead activities continue to feel difficult with LUE due to weakness and tightness.

Pain/Symptom Level:

**OBJECTIVE:** See measurements below. Progressed treatment to include standing rows and bent over rows. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: ADL modification, Body mechanics education and HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments
Posture - Trunk / Lower Qtr.	Lumbar Paraspinals			
Lumbar - Palpation	Gluteal Musculature			
	Piriformis			
	Lumbosacral Region			
	Lumbar Spinous Process(es)			
	Flexion			
Lumbar - AROM	Extension			
	Lateral Flexion (R)			
	Lateral Flexion (L)			
	Rotation (R)			
	Rotation (L)			
	Side Gliding (R)			
	Side Gliding (L)			
	All Dermatomes (R LE)			
Lumbar - Neuro Scan - Dermatomes	All Dermatomes (L LE)			
	Iliopsoas (L1,L2,L3) - R			
Lumbar - Neuro Scan - Myotomes	Quadriceps (L2,L3,L4) - R			
	Anterior Tibialis (L4) - R			
	Extensor Hallucis Longus (L5) - R			
	Gastrocnemius (S1) - R			
	Peroneus Longus / Brevis (S1) - R			
	Iliopsoas (L1,L2,L3) - L			
	Quadriceps (L2,L3,L4) - L			
	Anterior Tibialis (L4) - L			
	Extensor Hallucis Longus (L5) - L			
	Gastrocnemius (S1) - L			
	Peroneus Longus / Brevis (S1) - L			

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FROM

Patient: Arthur C Davis DOB: REDACTED Date of Note: 02-13-2014 STAR account# 4798 Page 2 of 4

	Straight Leg Raise (R)			
Lumbar - Special Tests	Straight Leg Raise (L)			
	LE Flexibility (R)			
Lower Extremity - Flexibility	LE Flexibility (L)			
	Core Strength			
General Core Strength	Shoulder Flexion (L)	Min. limited	Min. limited	
Shoulder - AROM	Shoulder Abduction (L)	138 Degrees	140 Degrees	
	Functional Reach Internal Rotation (L)	95 Degrees	95 Degrees	
	Functional Reach External Rotation (L)	T10	L3	
	Shoulder Scaption with Functional ER	T6	T4	
	Shoulder Flexion (L)	145 Degrees		
Shoulder - PROM	Shoulder Abduction (L)	160 Degrees	160 Degrees	
	Shoulder External Rotation (L)	140 Degrees	140 Degrees	
	Shoulder Internal Rotation (L)	80 Degrees	80 Degrees	
	Shoulder PROM (L)	60 Degrees	60 Degrees	
		Min. limited	Min. limited	

**ASSESSMENT:** Pt tolerated treatment well today. Pt continues to have decreased ROM, partially due to size of RTC tear. Pt continues to have difficulty with overhead activities due to active tightness and weakness, especially with behind the head and behind the back motions. Pt is progressing slower than expected toward treatment goals. Pt has progressed slower due to size of initial tear. Pt will continue to benefit from skilled PT to increase LUE strength and active motion.

**Current Goals**

**Outcome**

Pt will report less than 3/10 pain in 2 weeks at rest	Partially Met
Pt to be instructed in HEP	Met
Pt will demonstrate improved postural awareness in 2 weeks evidenced by PT observation of movement patterns in clinic	Met
Pt will improve L shoulder flexion and ER Muscle strength to 4+/5 in 6 weeks	Partially Met
Pt will report no more than 2/10 pain at worst in 4 weeks	Partially Met
Pt will demonstrate ability to perform all upper body dressing tasks without difficulty or pain in 6 weeks	Met
Pt will increase L shoulder AROM to at least 150 degrees of scaption in 6 weeks	Not Met
Pt will be able to perform all normal work related tasks without pain or difficulty in 8 weeks	Not Met
Pt will be able to reach overhead into elevated cabinets without increase in pain in 8 weeks	Partially Met
Pt will tolerate at least 30 min continuous sitting activity without increase in low back pain in 6 weeks	Not Met
Pt will report uninterrupted sleep from low back pain in 4 weeks	Partially Met

**New Goals**

--	--

**PLAN:** Pt to continue PT on Left shoulder for remaining two visits. PT recommends continued therapy on left shoulder for 2x/week for 4 more weeks or until patient returns to MD in March for RUE follow-up. MD reports to hold off on RUE PROM and therapy at this time until further follow up.

This note has been electronically signed by **Kyle Todd PT**

FROM

(THU) MAR 20 2014 20:58/ST. 20:14/No. 6814013682 P 91

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 02-13-2014

STAR account# 4798

Page 3 of 4

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues to be on hold for PT**TIME IN:****TIME OUT:**

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		22
Functional activities*		10
Manual therapy tech*		22
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	22 min to L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each	
Tband IR	BTB 3 x 15 each	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#3lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #15	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	HOLD- may attempt LLE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	
Table slides ER	5 min	

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FROM

(THU)MAR 20 2014 20:58/ST. 20:14/No. 6814013682 P 92

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 02-13-2014

STAR account# 4798

Page 4 of 4

**Total Treatment Time: 54 minutes**

*This note has been electronically signed by Kyle Todd PT*

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(THU)MAR 20 2014 20:59/ST. 20:14/No. 6814013682 P 93



## DAILY TREATMENT NOTE

Date of Note: 02-18-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 01-31-14

**SUBJECTIVE:** Pt reports no significant change in LUE since previous visit. Pt reports being able to reach behind back with more ROM than last week. Pt. reports compliance and good tolerance of HEP. Pt reports weakness and overhead activities still difficult.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. Held on ther ex and activities that required BUE today due to RUE RTC repair. The following procedures were performed at distinctly different time intervals from each other; functional activities and manual techniques. Pt received education on the following: HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt able to perform LUE ther ex with min difficulty and without increase in pain. Pt continues to have decreased active ROM due to weakness and tightness in all planes, but improved since last week.

**Current Goals**

**Outcome**

**New Goals**

**PLAN:** Continue with current treatment plan.

This note has been electronically signed by Kyle Todd PT



FROM

(THU) MAR 20 2014 20:59/ST. 20:14/No. 6814013682 P 94

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 02-18-2014

STAR account# 4798

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues to be on hold for PT

TIME IN: 11:00AM

TIME OUT: 11:57AM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		23
Functional activities*		12
Manual therapy tech*		22
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	22 min to L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each	
Tband IR	BTB 3 x 15 each	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#3lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #15	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min with LUE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	
Table slides ER	5 min- npt	

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3/21/2014 12:38 PM

AETNA -> 18666671987

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FROM

(THU) MAR 20 2014 20:59/ST. 20:14/No. 6814013682 P 95

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 02-18-2014

STAR account# 4798

Page 3 of 3

Total Treatment Time: 57 minutes

This note has been electronically signed by Kyle Todd PT

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## DAILY TREATMENT NOTE

Date of Note: 02-21-14

PATIENT NAME: Arthur C Davis

PHYSICIAN: R James Renfro Jr MD

PATIENT DOB: REDACTED

STAR Account #: 474798

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 01-31-14

**SUBJECTIVE:** Pt brought in new script for PROM to R shoulder today. Pt reports elevation above left shoulder continues to feel tight and difficult to perform ADL's above shoulder height. Pt reports no change in RUE due to surgical precautions of PROM only.

**Pain/Symptom Level:**

**OBJECTIVE:** See measurements below. Progressed treatment to include PROM and joint mobs to Right shoulder. Held on RUE exercises today due to surgical precautions to RUE. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Diagnosis/anatomy/healing process education, HEP instruction and Surgical precautions.

Test	Test Description	Current Results	Previous Results	Comments
Posture - Trunk / Lower Qtr.	Lordosis	WNL	WNL	
Shoulder - AROM	Shoulder Flexion (L)	140 Degrees	138 Degrees	
	Shoulder Abduction (L)	98 Degrees	95 Degrees	
	Functional Reach Internal Rotation (L)	T10	T10	
	Functional Reach External Rotation (L)	T6	T6	
	Shoulder Scaption with Functional ER	145 Degrees	145 Degrees	
	Shoulder Flexion (R)	NPT		
	Shoulder Abduction (R)	NPT		
	Functional Reach Internal Rotation (R)	NPT		
	Functional Reach External Rotation (R)	NPT		
Shoulder - PROM	Shoulder Flexion (L)	163 Degrees	160 Degrees	
	Shoulder Abduction (L)	145 Degrees	140 Degrees	
	Shoulder External Rotation (L)	88 Degrees	80 Degrees	
	Shoulder Internal Rotation (L)	62 Degrees	60 Degrees	
	Shoulder PROM (L)	Min. limited	Min. limited	
	Shoulder Flexion (R)	135	NPT	
	Shoulder Abduction (R)	110	NPT	
	Shoulder External Rotation (R)	70	NPT	
	Shoulder Internal Rotation (R)	45	NPT	
Shoulder - Strength	Shoulder Flexion (R)	NPT		
	Shoulder Abduction (R)	NPT		
	Shoulder External Rotation (R)	NPT		
	Shoulder Internal Rotation (R)	NPT		

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FROM

(THU) MAR 20 2014 20:59/ST. 20:14/No. 6814013682 P 97

Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 02-21-2014

STAR account# 4798

Page 2 of 4

	Rotation (R)			
	Shoulder Flexion (L)	4/5		
	Shoulder Abduction (L)	4/5		
	Shoulder External Rotation (L)	4-/5		
	Shoulder Internal Rotation (L)	4-/5		

**ASSESSMENT:** Pt tolerated treatment well today. Pt able to demonstrate increased PROM of LUE with continued tightness at end range in all planes. Pt able to demonstrate good PROM of RUE for first visit for therapy on RUE. Pt continues to increase strength in LUE, through elevation activities continue to be difficult. Pt continues to demonstrate mild compensation of left shoulder with elevation activities. Pt will continue to benefit from skilled PT for LUE and RUE shoulders due to decreased ROM and weakness.

**Current Goals****Outcome**

Pt will report less than 3/10 pain in 2 weeks at rest	Partially Met
Pt to be instructed in HEP	Met
Pt will demonstrate improved postural awareness in 2 weeks evidenced by PT observation of movement patterns in clinic	Met
Pt will improve L shoulder flexion and ER Muscle strength to 4+/5 in 6 weeks	Partially Met
Pt will report no more than 2/10 pain at worst in 4 weeks	Partially Met
Pt will demonstrate ability to perform all upper body dressing tasks without difficulty or pain in 6 weeks	Met
Pt will increase L shoulder AROM to at least 150 degrees of scaption in 6 weeks	Not Met
Pt will be able to perform all normal work related tasks without pain or difficulty in 8 weeks	Not Met
Pt will be able to reach overhead into elevated cabinets without increase in pain in 8 weeks	Partially Met
Pt will tolerate at least 30 min continuous sitting activity without increase in low back pain in 6 weeks	Not Met
Pt will report uninterrupted sleep from low back pain in 4 weeks	Partially Met

**New Goals**

Pt will increase PROM of RUE to 160° flexion/scaption, 90° ER, 60° IR within 4 weeks
Pt will be knowledgeable of surgical precautions of RUE within 2 weeks
Pt will increase PROM to WNL within 6 weeks

**PLAN:** Continue progression per protocol.

This note has been electronically signed by Kyle Todd PT

FROM

(THU) MAR 20 2014 21:00/ST. 20:14/No. 6814013682 P 98

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 02-21-2014

STAR account#

4798

Page 3 of 4

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues to be on hold for PT

TIME IN: 10:55AM

TIME OUT: 12:00PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		23
Functional activities*		12
Manual therapy tech*		30
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	15 min to RUE and LUE	
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each	
Tband IR	BTB 3 x 15 each	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#3lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #15	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min with LUE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	
Table slides ER	5 min- npt	

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FROM

(THU) MAR 20 2014 21:00/ST. 20:14/No. 6814013682 P 99

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 02-21-2014

STAR account# 4798

Page 4 of 4

Total Treatment Time: 65 minutes

This note has been electronically signed by Kyle Todd PT

(THU)MAR 20 2014 21:00/ST. 20:14/No. 6814013682 P100



## DAILY TREATMENT NOTE

Date of Note: 02-25-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 03-11-14

**SUBJECTIVE:** Pt reports he didn't take any tylenol this morning and is having more pain "all over". Pt states his R shoulder is feeling "really good"

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Diagnosis/anatomy/healing process education.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt continues to progress with PROM to R shoulder and AAROM and gentle AROM/strengthening to L shoulder.

**Current Goals**

**Outcome**

**New Goals**

**PLAN:** Continue with current treatment plan.

*This note has been electronically signed by Jason Barclay PT*

FROM

(THU) MAR 20 2014 21:00/ST. 20:14/No. 6814013682 P101

Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 02-25-2014

STAR account# 4798

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues to be on hold for PT**TIME IN:** 11:20AM**TIME OUT:** 12:23PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		23
Functional activities*		12
Manual therapy tech*		25
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	25 min to RUE and LUE	
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each (black tband)	
Tband IR	BTB 3 x 15 each (black tband)	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#5lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #15	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min with LUE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Walks	HOLD	
Table slides ER	5 min- npt	

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FROM

(THU) MAR 20 2014 21:00/ST. 20:14/No. 6814013682 P102

Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 02-25-2014

STAR account# 4798

Page 3 of 3

**Total Treatment Time:** 60 minutes.

*This note has been electronically signed by Jason Barclay PT*

Murfreesboro 1725 Medical Center Pkwy, Ste 130 Murfreesboro, TN 37129-2248 Phone: 615-217-0259, FAX: 615-217-1290



## DAILY TREATMENT NOTE

Date of Note: 02-28-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 03-11-14

**SUBJECTIVE:** Pt states LUE shoulder feeling good, able to increase HEP at home with weights. Pt reports RUE shoulder "feels good, almost too good." Pt states continued difficulty with reaching behind head and behind the back. Pt. reports compliance and good tolerance of HEP.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Body mechanics education and HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt continues to increase ROM in bilateral shoulders. Pt continues to have pain at current end range in all planes of bilateral shoulders.

**Current Goals**

**Outcome**

**New Goals**

**PLAN:** Continue progression per protocol.

*This note has been electronically signed by **Kyle Todd PT***

FROM

(THU) MAR 20 2014 21:01/ST. 20:14/No. 6814013682 P104

Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 02-28-2014

STAR account# 4798

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues to be on hold for PT**TIME IN:****TIME OUT:**

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		23
Functional activities*		8
Manual therapy tech*		25
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	25 min to RUE and LUE	
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each (black tband)	
Tband IR	BTB 3 x 15 each (black tband)	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#5lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #15	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min with LUE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption- resume nv	
Wall Washes	HOLD	
Table slides ER	5 min- npt	

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FROM

(THU) MAR 20 2014 21:01/ST. 20:14/No. 6814013682 P105

Patient: Arthur C Davis

DOB: 1

REDACTED

Date of Note: 02-28-2014

STAR account# 4798

Page 3 of 3

Total Treatment Time: 56 minutes

This note has been electronically signed by Kyle Todd PT



## DAILY TREATMENT NOTE

Date of Note: 03-06-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 03-11-14

**SUBJECTIVE:** Pt states RUE has been feeling good. Pt states he feels as through RUE is as good as LUE in PROM. Pt states he has started having "popping,clicking" in LUE with active movement. Pt states no pain with movement in LUE and AROM is better, but new symptoms of clicking worry him. Pt states still limited in RUE use due to surgical precautions, but LUE doing better with overhead activities.

Pain/Symptom Level:

**OBJECTIVE:** See measurements below. Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Body mechanics education, Diagnosis/anatomy/healing process education, HEP instruction and Plan of care.

Test	Test Description	Current Results	Previous Results	Comments
Shoulder - AROM	Shoulder Flexion (L)	160 Degrees	140 Degrees	
	Shoulder Abduction (L)	115 Degrees	98 Degrees	
	Functional Reach Internal Rotation (L)	T10	T10	
	Functional Reach External Rotation (L)	T6	T6	
	Shoulder Scaption with Functional ER	160	145 Degrees	
	Shoulder Flexion (R)	NPT	NPT	
	Shoulder Abduction (R)	NPT	NPT	
	Functional Reach Internal Rotation (R)	NPT	NPT	
	Functional Reach External Rotation (R)	NPT	NPT	
Shoulder - PROM	Shoulder Flexion (L)	165 Degrees	163 Degrees	
	Shoulder Abduction (L)	150 Degrees	145 Degrees	
	Shoulder External Rotation (L)	88 Degrees	88 Degrees	
	Shoulder Internal Rotation (L)	65 Degrees	62 Degrees	
	Shoulder PROM (L)	WFL	Min. limited	
	Shoulder Flexion (R)	145	135	
	Shoulder Abduction (R)	120	110	
	Shoulder External Rotation (R)	75	70	
	Shoulder Internal Rotation (R)	50	45	
Shoulder - Strength	Shoulder Flexion (R)	NPT	NPT	
	Shoulder Abduction (R)	NPT	NPT	
	Shoulder External Rotation (R)	NPT	NPT	
	Shoulder Internal Rotation (R)	NPT	NPT	

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FROM

(THU) MAR 20 2014 21:01/ST. 20:14/No. 6814013682 P107

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 03-06-2014

STAR account# 4798

Page 2 of 4

	Shoulder Flexion (L)	4/5	4/5	
	Shoulder Abduction (L)	4/5	4/5	
	Shoulder External Rotation (L)	4/5	4-/5	
	Shoulder Internal Rotation (L)	4/5	4-/5	

**ASSESSMENT:** Pt tolerated treatment well today. Pt continues to increase ROM in bilateral shoulders. Pt demonstrates good AROM, still decreased compared to WNL, but within functional limits. Pt demonstrates TTP at lesser tubercle and at supraspinatus. Pt able to improve PROM of RUE, but still limited compared to normal ROM.

**Current Goals****Outcome**

Pt will report less than 3/10 pain in 2 weeks at rest	Partially Met
Pt to be instructed in HEP	Met
Pt will demonstrate improved postural awareness in 2 weeks evidenced by PT observation of movement patterns in clinic	Met
Pt will improve L shoulder flexion and ER Muscle strength to 4+/5 in 6 weeks	Partially Met
Pt will report no more than 2/10 pain at worst in 4 weeks	Partially Met
Pt will demonstrate ability to perform all upper body dressing tasks without difficulty or pain in 6 weeks	Met
Pt will increase L shoulder AROM to at least 150 degrees of scaption in 6 weeks	Met
Pt will be able to perform all normal work related tasks without pain or difficulty in 8 weeks	Not Met
Pt will be able to reach overhead into elevated cabinets without increase in pain in 8 weeks	Partially Met
Pt will tolerate at least 30 min continuous sitting activity without increase in low back pain in 6 weeks	Other
Pt will report uninterrupted sleep from low back pain in 4 weeks	Other
Pt will increase PROM of RUE to 160° flexion/scaption, 90 ER, 60 IR within 4 weeks	Not Met
Pt will be knowledgeable of surgical precautions of RUE within 2 weeks	Met
Pt will increase PROM to WNL within 6 weeks	Not Met

**New Goals**

--	--

**PLAN:** Continue progression per protocol for remaining 5 visits, then recommend 2-3x/week for 4 more weeks.

This note has been electronically signed by **Kyle Todd PT**

FROM

(THU) MAR 20 2014 21:01/ST. 20:14/No. 6814013682 P108

Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 03-06-2014

STAR account# 4798

Page 3 of 4

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues to be on hold for PT**TIME IN:** 11:00AM**TIME OUT:** 12:00PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		23
Functional activities*		12
Manual therapy tech*		25
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	28 min to RUE and LUE	
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each (black tband)	
Tband IR	BTB 3 x 15 each (black tband)	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#5lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #15	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min with LUE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	
Table slides ER	5 min- npt	

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FROM

(THU)MAR 20 2014 21:01/ST. 20:14/No. 6814013682 P109

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 03-06-2014

STAR account# 4798

Page 4 of 4

Total Treatment Time: 60 minutes

This note has been electronically signed by Kyle Todd PT

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(THU) MAR 20 2014 21:02/ST. 20:14/No. 6814013682 P110



## DAILY TREATMENT NOTE

Date of Note: 03-07-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 03-11-14

**SUBJECTIVE:** Pt reports feeling more sore today after yesterdays visit, describing as muscular soreness. Pt reports "popping/clicking" continues, but not painful today. Pt. reports compliance and good tolerance of HEP.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Body mechanics education, HEP instruction and Surgical precautions.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt able to tolerate increased PROM on BUE today. LUE feels more tight at end range, but pt able to tolerate stretch in all planes.

**Current Goals**

**Outcome**

**New Goals**

**PLAN:** Continue progression per protocol.

*This note has been electronically signed by Kyle Todd PT*

FROM

(THU) MAR 20 2014 21:02/ST. 20:14/No. 6814013682 P111

Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 03-07-2014

STAR account# 4798

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues to be on hold for PT**TIME IN:** 10:55AM**TIME OUT:** 11:50AM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		20
Functional activities*		10
Manual therapy tech*		25
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	28 min to RUE and LUE	
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each (black tband)	
Tband IR	BTB 3 x 15 each (black tband)	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#5lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #15	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min with LUE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	
Table slides ER	5 min- npt	

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FROM

(THU)MAR 20 2014 21:02/ST. 20:14/No. 6814013682 P112

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 03-07-2014

STAR account# 4798

Page 3 of 3

Total Treatment Time: 55 minutes

*This note has been electronically signed by Kyle Todd PT*

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(THU)MAR 20 2014 21:02/ST. 20:14/No. 6814013682 P113



## DAILY TREATMENT NOTE

Date of Note: 03-10-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 03-11-14

**SUBJECTIVE:** Pt reports feeling as LUE is getting stronger, still limited at end range with active movement, but less difficult. Pt states using RUE to pour a glass of orange juice this past week, forgot surgical precautions, but did not have any pain with the active movement. Pt. reports compliance and good tolerance of HEP.

### Pain/Symptom Level:

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Body mechanics education, HEP instruction and Surgical precautions.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt continues to increase in ROM and strength of LUE and ROM of RUE. Pt still limited at end ranges of LUE, but demonstrating functional ROM.

### Current Goals

### Outcome

### New Goals

**PLAN:** Continue progression per protocol.

*This note has been electronically signed by **Kyle Todd PT***

FROM

(THU)MAR 20 2014 21:02/ST. 20:14/No. 6814013682 P114

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 03-10-2014

STAR account# 4798

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues to be on hold for PT**TIME IN:****TIME OUT:**

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		20
Functional activities*		12
Manual therapy tech*		25
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	28 min to RUE and LUE	
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each (black tband)	
Tband IR	3 x 10 performed @ 90/90 today	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#5lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #15	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min with LUE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	
Table slides ER	5 min- npt	

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FROM

(THU) MAR 20 2014 21:02/ST. 20:14/No. 6814013682 P115

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 03-10-2014

STAR account# 4798

Page 3 of 3

Total Treatment Time: 57 minutes

*This note has been electronically signed by Kyle Todd PT*

(THU) MAR 20 2014 21:02/ST. 20:14/No. 6814013682 P116



## DAILY TREATMENT NOTE

Date of Note: 03-12-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 04-25-14

**SUBJECTIVE:** Pt has seen MD since last visit. Pt reports the MD is not concerned with the noise in his shoulder. Pt reports the MD was pleased with progress and that he needs more strengthening. Pt. reports compliance and good tolerance of HEP. Pt states he is scheduled for surgery on his knee 4/18/14

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment to include further ROM and gentle strengthening per new MD script.. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Diagnosis/anatomy/healing process education.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt was able to perform additional AAROM and low level of abduction strengthening exercises well without increased pain. Pt is progressing well.

**Current Goals**

**Outcome**

**New Goals**

**PLAN:** Continue progression per protocol. See new script for advancement

*This note has been electronically signed by **Jason Barclay PT***

FROM

(THU) MAR 20 2014 21:02/ST. 20:14/No. 6814013682 P117

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 03-12-2014

STAR account# 4798

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues to be on hold for PT**TIME IN:** 09:35AM**TIME OUT:** 11:11AM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		45
Functional activities*		12
Manual therapy tech*		25
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	28 min to RUE and LUE	
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	5 min scaption	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	RTB 3 x 10 each	
Tband ER	BTB 3 x 15 each (black tband)	
Tband IR	3 x 10 performed @ 90/90 today	
Isometric ER/IR	5" x 10 each	
Isometric flex/abd	Add NV	
Supine Cane flexion	5" x 20	
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#5lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x 10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #15	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min with LUE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	

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FROM

(THU) MAR 20 2014 21:03/ST. 20:14/No. 6814013682 P118

Patient: Arthur C Davis

DOB: 1

REDACTED

Date of Note: 03-12-2014

STAR account# 4795

Page 3 of 3

Table slides ER

5 min- npt

**Total Treatment Time: 82 minutes***This note has been electronically signed by Jason Barclay PT*

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(THU) MAR 20 2014 21:03/ST. 20:14/No. 6814013682 P119



## DAILY TREATMENT NOTE

Date of Note: 03-17-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 04-25-14

**SUBJECTIVE:** Pt states there has been no significant change in pain/symptoms since the last visit. Pt states he feels he is continuing to progress.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Diagnosis/anatomy/healing process education.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt continues to respond well to manual techniques for improving shoulder ROM and progressing well with rtc and periscapular strengthening per protocol

**Current Goals**

**Outcome**

**New Goals**

**PLAN:** Continue progression per protocol.

*This note has been electronically signed by **Jason Barclay PT***

FROM

(THU)MAR 20 2014 21:03/ST. 20:14/No. 6814013682 P120

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 03-17-2014

STAR account# 4798

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues ot be on hold for PT**TIME IN:** 11:05AM**TIME OUT:** 12:20PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		43
Functional activities*		12
Manual therapy tech*		20
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min to RUE and LUE	
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	5 min scaption	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	BTB 3 x 10 each	
Tband ER	BTB 3 x 15 each (black tband)	
Tband IR	3 x 10 performed @ 90/90 today	
Isometric ER/IR	5" x 10 each	
Isometric flex/abd	Add NV	
Supine Cane flexion	5" x 20	
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#5lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #20	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min with LUE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	

Murfreesboro 1725 Medical Center Pkwy, Ste 130 Murfreesboro, TN 37128-2248 Phone: 615-217-0258, FAX: 615-217-1290

FROM

(THU) MAR 20 2014 21:03/ST. 20:14/No. 6814013682 P121

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 03-17-2014

STAR account# 4798

Page 3 of 3

Table slides ER	5 min- npt	
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**Total Treatment Time: 75 minutes***This note has been electronically signed by Jason Barclay PT*

FROM

(THU)MAR 20 2014 21:03/ST. 20:14/No. 6814013682 P122

**DAILY TREATMENT NOTE****Date of Note:** 03-19-14**PATIENT NAME:** Arthur C Davis**PATIENT DOB:** REDACTED**STAR Account #:** 474798**PHYSICIAN:** R James Renfro Jr MD**DIAGNOSIS:** Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51**Next MD Visit:** 04-25-14

**SUBJECTIVE:** Pt reports that right shoulder was hurting a little more yesterday, but not sure why he had increased pain. Pt states left shoulder popping less and appears to be strengthened. Pt states left shoulder not bothering him as much anymore. Pt. reports compliance and good tolerance of HEP.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Body mechanics education, Diagnosis/anatomy/healing process education and HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt was able to perform majority of the ex for bilateral shoulders, did not perform supine exercises due to increased low back pain today. Pt able to demonstrate increased ROM on RUE, ER to normal limits in PROM. Pt continues to have min tightness in LUE in all planes, but able to tolerate PROM to WNL.

**Current Goals****Outcome**

--	--

**New Goals**

--	--

**PLAN:** Continue progression per protocol.

*This note has been electronically signed by **Kyle Todd PT***

FROM

(THU)MAR 20 2014 21:03/ST. 20:14/No. 6814013682 P123

Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 03-19-2014

STAR account# 4798

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues to be on hold for PT**TIME IN:** 10:00AM**TIME OUT:** 11:05AM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*	supine ther ex not performed due to back pain	35
Functional activities*		10
Manual therapy tech*		20
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min to RUE and LUE	
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	5 min scaption	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	BTB 3 x 10 each	
Tband ER	BTB 3 x 15 each (black tband)	
Tband IR	3 x 10 performed @ 90/90 today	
Isometric ER/IR	5" x 10 each	
Isometric flex/abd	Add NV	
Supine Cane flexion	5" x 20	
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#5lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x 10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #20	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min with LUE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	

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FROM

(THU) MAR 20 2014 21:04/ST. 20:14/No. 6814013682 P124

Patient: Arthur C Davis DOB: REDACTED Date of Note: 03-19-2014 STAR account# 4798 Page 3 of 3

Table slides ER	5 min- npt	
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**Total Treatment Time:** 65 minutes

*This note has been electronically signed by Kyle Todd PT*



## DAILY TREATMENT NOTE

Date of Note: 02-25-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 03-11-14

**SUBJECTIVE:** Pt reports he didn't take any tylenol this morning and is having more pain "all over". Pt states his R shoulder is feeling "really good"

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Diagnosis/anatomy/healing process education.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt continues to progress with PROM to R shoulder and AAROM and gentle AROM/strengthening to L shoulder.

**Current Goals**

**Outcome**

--	--

**New Goals**

--	--

**PLAN:** Continue with current treatment plan.

*This note has been electronically signed by Jason Barclay PT*



FROM

(WED) MAR 19 2014 20:19/ST. 20:12/No. 6814013655 P 18

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 02-25-2014

STAR account#: 498

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues to be on hold for PT

TIME IN: 11:20AM

TIME OUT: 12:23PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		23
Functional activities*		12
Manual therapy tech*		25
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	25 min to RUE and LUE	
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each (black tband)	
Tband IR	BTB 3 x 15 each (black tband)	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#5lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x 10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #15	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min with LUE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	
Table slides ER	5 min- npt	

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DCN: 140320054895 PAGE: 003 SEQUENCE: SWF0320201400736001

Case 1:15-cv-00086 Document 13-1 Filed 02/18/16 Page 645 of 1151 Page ID #: 639

FROM

(WED) MAR 19 2014 20:19/ST. 20:12/No. 6814013655 P 19

Patient: Arthur C Davis      DOB: REDACTED      Date of Note: 02-25-2014      STAR account#: 4. /98      Page 3 of 3

**Total Treatment Time:** 60 minutes

*This note has been electronically signed by Jason Barclay PT*

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DCN: 140320054895 PAGE: 005 SEQUENCE: SWF0320201400736001



## DAILY TREATMENT NOTE

Date of Note: 02-28-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 03-11-14

**SUBJECTIVE:** Pt states LUE shoulder feeling good, able to increase HEP at home with weights. Pt reports RUE shoulder "feels good, almost too good." Pt states continued difficulty with reaching behind head and behind the back. Pt. reports compliance and good tolerance of HEP.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Body mechanics education and HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt continues to increase ROM in bilateral shoulders. Pt continues to have pain at current end range in all planes of bilateral shoulders.

Current Goals	Outcome

New Goals

**PLAN:** Continue progression per protocol.

*This note has been electronically signed by Kyle Todd PT*

FROM

(WED) MAR 19 2014 20:19/ST. 20:12/No. 6814013655 P 21

Patient: Arthur C Davis DOB: [REDACTED] Date of Note: 02-28-2014 STAR account#: 4. /98

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues to be on hold for PT**TIME IN:****TIME OUT:**

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		23
Functional activities*		8
Manual therapy tech*		25
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	25 min to RUE and LUE	
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each (black tband)	
Tband IR	BTB 3 x 15 each (black tband)	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#5lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #15	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min with LUE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption- resume nv	
Wall Washes	HOLD	
Table slides ER	5 min- npt	

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DCN: 140320054895 PAGE: 009 SEQUENCE: SWF0320201400736001

FROM

(WED) MAR 19 2014 20:19/ST. 20:12/No. 6814013655 P 22

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 02-28-2014

STAR account#: 4 98

Page 3 of 3

**Total Treatment Time: 56 minutes**

*This note has been electronically signed by Kyle Todd PT*

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DCN: 140320054895 PAGE: 011 SEQUENCE: SWF0320201400736001



## DAILY TREATMENT NOTE

Date of Note: 03-06-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4

Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 03-11-14

**SUBJECTIVE:** Pt states RUE has been feeling good. Pt states he feels as through RUE is as good as LUE in PROM. Pt states he has started having "popping,clicking" in LUE with active movement. Pt states no pain with movement in LUE and AROM is better, but new symptoms of clicking worry him. Pt states still limited in RUE use due to surgical precautions, but LUE doing better with overhead activities.

**Pain/Symptom Level:**

**OBJECTIVE:** See measurements below. Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Body mechanics education, Diagnosis/anatomy/healing process education, HEP instruction and Plan of care.

Test	Test Description	Current Results	Previous Results	Comments
Shoulder - AROM	Shoulder Flexion (L)	160 Degrees	140 Degrees	
	Shoulder Abduction (L)	115 Degrees	98 Degrees	
	Functional Reach Internal Rotation (L)	T10	T10	
	Functional Reach External Rotation (L)	T6	T6	
	Shoulder Scaption with Functional ER	160	145 Degrees	
	Shoulder Flexion (R)	NPT	NPT	
	Shoulder Abduction (R)	NPT	NPT	
	Functional Reach Internal Rotation (R)	NPT	NPT	
	Functional Reach External Rotation (R)	NPT	NPT	
Shoulder - PROM	Shoulder Flexion (L)	165 Degrees	163 Degrees	
	Shoulder Abduction (L)	150 Degrees	145 Degrees	
	Shoulder External Rotation (L)	88 Degrees	88 Degrees	
	Shoulder Internal Rotation (L)	65 Degrees	62 Degrees	
	Shoulder PROM (L)	WFL	Min. limited	
	Shoulder Flexion (R)	145	135	
	Shoulder Abduction (R)	120	110	
	Shoulder External Rotation (R)	75	70	
	Shoulder Internal Rotation (R)	50	45	
Shoulder - Strength	Shoulder Flexion (R)	NPT	NPT	
	Shoulder Abduction (R)	NPT	NPT	
	Shoulder External Rotation (R)	NPT	NPT	
	Shoulder Internal Rotation (R)	NPT	NPT	

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Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 03-06-2014

STAR account#: 4 98

Page 2 of 4

	Shoulder Flexion (L)	4/5	4/5	
	Shoulder Abduction (L)	4/5	4/5	
	Shoulder External Rotation (L)	4/5	4-/5	
	Shoulder Internal Rotation (L)	4/5	4-/5	

**ASSESSMENT:** Pt tolerated treatment well today. Pt continues to increase ROM in bilateral shoulders. Pt demonstrates good AROM, still decreased compared to WNL, but within functional limits. Pt demonstrates TTP at lesser tubercle and at supraspinatus. Pt able to improve PROM of RUE, but still limited compared to normal ROM.

**Current Goals****Outcome**

Pt will report less than 3/10 pain in 2 weeks at rest	Partially Met
Pt to be instructed in HEP	Met
Pt will demonstrate improved postural awareness in 2 weeks evidenced by PT observation of movement patterns in clinic	Met
Pt will improve L shoulder flexion and ER Muscle strength to 4+/5 in 6 weeks	Partially Met
Pt will report no more than 2/10 pain at worst in 4 weeks	Partially Met
Pt will demonstrate ability to perform all upper body dressing tasks without difficulty or pain in 6 weeks	Met
Pt will increase L shoulder AROM to at least 150 degrees of scaption in 6 weeks	Met
Pt will be able to perform all normal work related tasks without pain or difficulty in 8 weeks	Not Met
Pt will be able to reach overhead into elevated cabinets without increase in pain in 8 weeks	Partially Met
Pt will tolerate at least 30 min continuous sitting activity without increase in low back pain in 6 weeks	Other
Pt will report uninterrupted sleep from low back pain in 4 weeks	Other
Pt will increase PROM of RUE to 160° flexion/scaption, 90 ER, 60 IR within 4 weeks	Not Met
Pt will be knowledgeable of surgical precautions of RUE within 2 weeks	Met
Pt will increase PROM to WNL within 6 weeks	Not Met

**New Goals**

--	--

**PLAN:** Continue progression per protocol for remaining 5 visits, then recommend 2-3x/week for 4 more weeks.

*This note has been electronically signed by **Kyle Todd PT***

FROM

(WED) MAR 19 2014 20:20/ST. 20:12/No. 6814013655 P 25

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 03-06-2014

STAR account#: 4. .98

Page 3 of 4

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues ot be on hold for PT**TIME IN:** 11:00AM**TIME OUT:** 12:00PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		23
Functional activities*		12
Manual therapy tech*		25
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	28 min to RUE and LUE	
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each (black tband)	
Tband IR	BTB 3 x 15 each (black tband)	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#5lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #15	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min with LUE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	
Table slides ER	5 min- npt	

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DCN: 140320054895 PAGE: 017 SEQUENCE: SWF0320201400736001



FROM

(WED) MAR 19 2014 20:21/ST. 20:12/No. 6814013655 P 26

Patient: Arthur C Davis

DOB: 1

REDACTED

Date of Note: 03-06-2014

STAR account#: 4. 98

Page 4 of 4

**Total Treatment Time: 60 minutes**

*This note has been electronically signed by Kyle Todd PT*

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DCN: 140320054895 PAGE: 019 SEQUENCE: SWF0320201400736001

Case 1:15-cv-00086 Document 13-1 Filed 02/18/16 Page 653 of 1151 PageID # 697



## DAILY TREATMENT NOTE

Date of Note: 03-07-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 03-11-14

**SUBJECTIVE:** Pt reports feeling more sore today after yesterdays visit, describing as muscular soreness. Pt reports "popping/clicking" continues, but not painful today. Pt. reports compliance and good tolerance of HEP.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Body mechanics education, HEP instruction and Surgical precautions.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt able to tolerate increased PROM on BUE today. LUE feels more tight at end range, but pt able to tolerate stretch in all planes.

**Current Goals**

**Outcomes**

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**New Goals**

--	--

**PLAN:** Continue progression per protocol.

*This note has been electronically signed by Kyle Todd PT*

FROM

(WED) MAR 19 2014 20:21/ST. 20:12/No. 6814013655 P. 28

Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 03-07-2014

STAR account#: 4 / 98

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues ot be on hold for PT**TIME IN:** 10:55AM**TIME OUT:** 11:50AM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		20
Functional activities*		10
Manual therapy tech*		25
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals- during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	28 min to RUE and LUE	
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each (black tband)	
Tband IR	BTB 3 x 15 each (black tband)	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#5lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #15	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min with LUE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	
Table slides ER	5 min- npt	

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DCN: 140320054895 PAGE: 023 SEQUENCE: SWF0320201400736001

FROM

(WED) MAR 19 2014 20:21/ST. 20:12/No. 6814013655 P 29

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 03-07-2014

STAR account#: 4. 00

Page 3 of 3

**Total Treatment Time: 55 minutes**

*This note has been electronically signed by Kyle Todd PT*

Murfreesboro 1725 Medical Center Pkwy, Ste 130 Murfreesboro, TN 37129-2248 Phone: 615-217-0259, FAX: 615-217-1290

DCN: 140320054895 PAGE: 025 SEQUENCE: SWF0320201400736001



## DAILY TREATMENT NOTE

Date of Note: 03-12-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 04-25-14

**SUBJECTIVE:** Pt has seen MD since last visit. Pt reports the MD is not concerned with the noise in his shoulder. Pt reports the MD was pleased with progress and that he needs more strengthening. Pt. reports compliance and good tolerance of HEP. Pt states he is scheduled for surgery on his knee 4/18/14

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment to include further ROM and gentle strengthening per new MD script.. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Diagnosis/anatomy/healing process education.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt was able to perform additional AAROM and low level of abduction strengthening exercises well without increased pain. Pt is progressing well.

**Current Goals**

**Outcome**

**New Goals**

**PLAN:** Continue progression per protocol. See new script for advancement

*This note has been electronically signed by Jason Barclay PT*

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 03-12-2014

STAR account#: 4. /98

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues ot be on hold for PT**TIME IN:** 09:35AM**TIME OUT:** 11:11AM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		45
Functional activities*		12
Manual therapy tech*		25
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	28 min to RUE and LUE	
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	5 min scaption	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	RTB 3 x 10 each	
Tband ER	BTB 3 x 15 each (black tband)	
Tband IR	3 x 10 performed @ 90/90 today	
Isometric ER/IR	5" x 10 each	
Isometric flex/abd	Add NV	
Supine Cane flexion	5" x 20	
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#5lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #15	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min with LUE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	

FROM

(WED) MAR 19 2014 20:22/ST. 20:12/No. 6814013655 P 32

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 03-12-2014

STAR account#: 4. /98

Page 3 of 3

Table slides ER	5 min- npt	
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Total Treatment Time: 82 minutes

*This note has been electronically signed by Jason Barclay PT*

**DAILY TREATMENT NOTE****Date of Note:** 03-17-14**PATIENT NAME:** Arthur C Davis**PATIENT DOB:** REDACTED**STAR Account #:** 474798**PHYSICIAN:** R James Renfro Jr MD**DIAGNOSIS:** Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51**Next MD Visit:** 04-25-14**SUBJECTIVE:** Pt states there has been no significant change in pain/symptoms since the last visit. Pt states he feels he is continuing to progress.**Pain/Symptom Level:****OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Diagnosis/anatomy/healing process education.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt continues to respond well to manual techniques for improving shoulder ROM and progressing well with rtc and periscapular strengthening per protocol**Current Goals****Outcome**

--	--

**New Goals**

--	--

**PLAN:** Continue progression per protocol.*This note has been electronically signed by Jason Barclay PT*



FROM

(WED) MAR 19 2014 20:22/ST. 20:12/No. 6814013655 P 34

Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 03-17-2014

STAR account#: 4. .98

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues ot be on hold for PT**TIME IN:** 11:05AM**TIME OUT:** 12:20PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		43
Functional activities*		12
Manual therapy tech*		20
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	20 min to RUE and LUE	
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	5 min scaption	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/\$AP	BTB 3 x 10 each	
Tband ER	BTB 3 x 15 each (black tband)	
Tband IR	3 x 10 performed @ 90/90 today	
Isometric ER/IR	5" x 10 each	
Isometric flex/abd	Add NV	
Supine Cane flexion	5" x 20	
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#5lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #20	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min with LUE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	

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DCN: 140320054895 PAGE: 035 SEQUENCE: SWF0320201400736001

FROM

(WED) MAR 19 2014 20:22/ST. 20:12/No. 6814013655 P. 35

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 03-17-2014

STAR account#: 4. /98

Page 3 of 3

Table slides ER	5 min- npt	
-----------------	------------	--

**Total Treatment Time: 75 minutes**

*This note has been electronically signed by **Jason Barclay PT***



## Facsimile Cover Sheet

DATE:

3-20-14

FROM:

Danielle Millians  
STAR Physical Therapy  
**Murfreesboro**  
1725 Medical Center Parkway Suite 130  
Murfreesboro, TN 37129  
**Phone** 615-217-0259  
**Fax** 615-217-1290

TO:

Phone  
Fax

AKinkawon Turner  
866-666-71987

MESSAGE:

Total Number of Pages (including cover): \_\_\_\_\_

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## DAILY TREATMENT NOTE

Date of Note: 02-07-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4

Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 01-31-14

**SUBJECTIVE:** Pt returns to therapy post-op RTC repair on right shoulder. Pt has not been released for therapy on RUE, only to have therapy on LUE. Pt. reports compliance and good tolerance of HEP. Pt reports having to use LUE more often due to new surgery on RUE. Pt states reaching, lifting, and overhead/behind the back activities continue to be most difficult.

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. Held on the ex or functional activities that required S/L, prone, or BUE. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: ADL modification, Body mechanics education, Diagnosis/anatomy/healing process education and HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments

**ASSESSMENT:** Pt tolerated treatment well today. Pt able to tolerate increased manual therapy. Pt continues to fatigue quickly with elevation activities. Pt. is progressing toward achievement of treatment goals as expected.

**Current Goals**

**Outcome**

--	--

**New Goals**

--	--

**PLAN:** Continue progression per protocol, holding on RUE PROM until released for PT.

*This note has been electronically signed by Kyle Todd PT*

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 02-07-2014

STAR account#: 4-4798

Page 2 of 3

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues ot be on hold for PT**TIME IN:****TIME OUT:**

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		20
Functional activities*		10
Manual therapy tech*		30
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	15 min to L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each	
Tband IR	BTB 3 x 15 each	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#3lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	HOLD- may attempt LLE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	
Table slides ER	5 min	

FROM

(WED) MAR 19 2014 20:14/ST. 20:12/No. 6814013655 P 4

Patient: Arthur C Davis DOB: REDACTED Date of Note: 02-07-2014 STAR account#: 4. .796 Page 3 of 3

**Total Treatment Time:** 60 minutes

*This note has been electronically signed by Kyle Todd PT*

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DCN: 140320054758 PAGE: 007 SEQUENCE: SWF0320201400721001



## DAILY TREATMENT NOTE

Date of Note: 02-11-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 01-31-14

**SUBJECTIVE:** Pt states feeling like he may have lost some motion in LUE since having to take 1 week off due to post-surgery on RUE. Pt reports compliance and good tolerance of HEP. Pt states that bathing, grooming, and upper body is difficult due to tightness and decreased use of RUE per surgical precautions. Pt reports that overhead reaching continues to be moderately difficult due to weakness and tightness, appearing to "lock up" around shoulder height.

**Pain/Symptom Level:**

**OBJECTIVE:** See measurements below. Progressed treatment per activity flowsheet. Held on ther ex and activities that required prone lying or RUE use today due to RUE surgical precautions. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: ADL modification, Body mechanics education and HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments
Posture - Trunk / Lower Qtr.	Lordosis	WNL	WNL	
Lumbar - Palpation	Lumbar Paraspinals		Moderate Muscle Spasm/Guarding	
	Gluteal Musculature		No Tenderness to Palpation	
	Piriformis		No Tenderness to Palpation	
	Lumbosacral Region		No Tenderness to Palpation	
	Lumbar Spinous Process(es)		No Tenderness to Palpation	
Lumbar - AROM	Flexion		Nil loss	
	Extension		Mod loss	
	Lateral Flexion (R)		Nil loss	
	Lateral Flexion (L)		Nil loss	
	Rotation (R)		Nil loss	
	Rotation (L)		Nil loss	
	Side Gliding (R)		Nil loss	
	Side Gliding (L)		Nil loss	
Lumbar - Neuro Scan - Dermatomes	All Dermatomes (R LE)		Intact to light touch, equal B, WNL	
	All Dermatomes (L LE)		Intact to light touch, equal B, WNL	
Lumbar - Neuro Scan - Myotomes	Iliopsoas (L1,L2,L3) - R		Normal	
	Quadriceps (L2,L3,L4) - R		Normal	
	Anterior Tibialis (L4) - R		Weak	
	Extensor Hallucis Longus (L5) - R		Normal	
	Gastrocnemius (S1) - R		Normal	
	Peroneus Longus / Brevis (S1) - R		Normal	

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Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 02-11-2014

STAR account#: 4. .98

Page 2 of 5

	Iliopsoas (L1,L2,L3) - L		Weak/painful	
	Quadriceps (L2,L3,L4) - L		Normal	
	Anterior Tibialis (L4) - L		Normal	
	Extensor Hallucis Longus (L5) - L		Normal	
	Gastrocnemius (S1) - L		Normal	
	Peroneus Longus / Brevis (S1) - L		Normal	
Lumbar - Special Tests	Straight Leg Raise (R)		-	
	Straight Leg Raise (L)		-	
Lower Extremity - Flexibility	LE Flexibility (R)		WNL	
	LE Flexibility (L)		WNL	
General Core Strength	Shoulder Flexion (L)		Min. limited	
Shoulder - AROM	Shoulder Abduction (L)	140 Degrees	135 Degrees	
	Functional Reach Internal Rotation (L)	95 Degrees	95 Degrees	
	Functional Reach External Rotation (L)	T10	L3	
	Shoulder Scaption with Functional ER	T6	T4	
	Shoulder Flexion (L)	145 Degrees		
Shoulder - PROM	Shoulder Abduction (L)	160 Degrees	160 Degrees	
	Shoulder External Rotation (L)	140 Degrees	140 Degrees	
	Shoulder Internal Rotation (L)	80 Degrees	80 Degrees	
	Shoulder PROM (L)	60 Degrees	60 Degrees	
		Min. limited	Min. limited	

**ASSESSMENT:** Pt tolerated treatment well today. Pt continues to increase in PROM, but continues to be limited in AROM due to weakness and continued functional tightness. Pt continues to demonstrate weakness in all planes of motion, limiting functional activities at home. Pt will continue to benefit from skilled PT to increase ROM of LUE as well as strength in shoulder height and overhead activities.

**Current Goals****Outcome**

Pt will report less than 3/10 pain in 2 weeks at rest	Partially Met
Pt to be instructed in HEP	Met
Pt will demonstrate improved postural awareness in 2 weeks evidenced by PT observation of movement patterns in clinic	Met
Pt will improve L shoulder flexion and ER Muscle strength to 4+/5 in 6 weeks	Partially Met
Pt will report no more than 2/10 pain at worst in 4 weeks	Partially Met
Pt will demonstrate ability to perform all upper body dressing tasks without difficulty or pain in 6 weeks	Met
Pt will increase L shoulder AROM to at least 150 degrees of scaption in 6 weeks	Not Met
Pt will be able to perform all normal work related tasks without pain or difficulty in 8 weeks	Not Met
Pt will be able to reach overhead into elevated cabinets without increase in pain in 8 weeks	Partially Met
Pt will tolerate at least 30 min continuous sitting activity without increase in low back pain in 6 weeks	Not Met
Pt will report uninterrupted sleep from low back pain in 4 weeks	Partially Met

**New Goals**

--	--

**PLAN:** Pt returns to MD this afternoon, Progress report given to patient and faxed to MD. Continue per protocol, increasing ROM and strength for remaining 3 visits, then continue per MD recommendations for LUE and for future RUE visits.

This note has been electronically signed by **Kyle Todd PT**



Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 02-11-2014

STAR account#: 4.798

Page 4 of 5

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues ot be on hold for PT**TIME IN:****TIME OUT:**

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		22
Functional activities*		10
Manual therapy tech*		30
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	15 min to L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each	
Tband IR	BTB 3 x 15 each	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#3lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #10	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	HOLD- may attempt LLE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	
Table slides ER	5 min	

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FROM

(WED) MAR 19 2014 20:15/ST. 20:12/No. 6814013655 P 8

Patient: Arthur C Davis DOB: REDACTED Date of Note: 02-11-2014 STAR account#: 4. .98 Page 5 of 5

**Total Treatment Time: 62 minutes**

*This note has been electronically signed by Kyle Todd PT*

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DCN: 140320054758 PAGE: 015 SEQUENCE: SWF0320201400721001



## DAILY TREATMENT NOTE

Date of Note: 02-13-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 01-31-14

**SUBJECTIVE:** Pt reports returned to MD yesterday and check up on RUE. Pt reports was not given new script for PT and not sure about continuing therapy. Pt states left shoulder "feels locked". Pt reports before surgery on RUE appeared to have good ROM and better strength, leading to increased function with LUE grooming, dressing, and bathing. Pt states all overhead activities continue to feel difficult with LUE due to weakness and tightness.

**Pain/Symptom Level:**

**OBJECTIVE:** See measurements below. Progressed treatment to include standing rows and bent over rows. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: ADL modification, Body mechanics education and HEP instruction.

Test	Test Description	Current Results	Previous Results	Comments
Posture - Trunk / Lower Qtr.	Lumbar Paraspinals			
Lumbar - Palpaton	Gluteal Musculature			
	Piriformis			
	Lumbosacral Region			
	Lumbar Spinous Process(es)			
	Flexion			
Lumbar - AROM	Extension			
	Lateral Flexion (R)			
	Lateral Flexion (L)			
	Rotation (R)			
	Rotation (L)			
	Side Gliding (R)			
	Side Gliding (L)			
	All Dermatomes (R LE)			
Lumbar - Neuro Scan - Dermatomes	All Dermatomes (L LE)			
Lumbar - Neuro Scan - Myotomes	Iliopsoas (L1,L2,L3) - R			
	Quadriceps (L2,L3,L4) - R			
	Anterior Tibialis (L4) - R			
	Extensor Hallucis Longus (L5) - R			
	Gastrocnemius (S1) - R			
	Peroneus Longus / Brevis (S1) - R			
	Iliopsoas (L1,L2,L3) - L			
	Quadriceps (L2,L3,L4) - L			
	Anterior Tibialis (L4) - L			
	Extensor Hallucis Longus (L5) - L			
	Gastrocnemius (S1) - L			
	Peroneus Longus / Brevis (S1) - L			

Murfreesboro 1725 Medical Center Pkwy, Ste 130 Murfreesboro, TN 37129-2248 Phone: 615-217-0259, FAX: 615-217-1290

Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 02-13-2014

STAR account#: 4.198

Page 2 of 4

	Straight Leg Raise (R)			
Lumbar - Special Tests	Straight Leg Raise (L)			
	LE Flexibility (R)			
Lower Extremity - Flexibility	LE Flexibility (L)			
	Core Strength			
General Core Strength	Shoulder Flexion (L)	Min. limited	Min. limited	
Shoulder - AROM	Shoulder Abduction (L)	138 Degrees	140 Degrees	
	Functional Reach Internal Rotation (L)	95 Degrees	95 Degrees	
	Functional Reach External Rotation (L)	T10	L3	
	Shoulder Scaption with Functional ER	T6	T4	
	Shoulder Flexion (L)	145 Degrees		
Shoulder - PROM	Shoulder Abduction (L)	160 Degrees	160 Degrees	
	Shoulder External Rotation (L)	140 Degrees	140 Degrees	
	Shoulder Internal Rotation (L)	80 Degrees	80 Degrees	
	Shoulder PROM (L)	60 Degrees	60 Degrees	
		Min. limited	Min. limited	

**ASSESSMENT:** Pt tolerated treatment well today. Pt continues to have decreased ROM, partially due to size of RTC tear. Pt continues to have difficulty with overhead activities due to active tightness and weakness, especially with behind the head and behind the back motions. Pt is progressing slower than expected toward treatment goals. Pt has progressed slower due to size of initial tear. Pt will continue to benefit from skilled PT to increase LUE strength and active motion.

**Current Goals****Outcome**

Pt will report less than 3/10 pain in 2 weeks at rest	Partially Met
Pt to be instructed in HEP	Met
Pt will demonstrate improved postural awareness in 2 weeks evidenced by PT observation of movement patterns in clinic	Met
Pt will improve L shoulder flexion and ER Muscle strength to 4+/5 in 6 weeks	Partially Met
Pt will report no more than 2/10 pain at worst in 4 weeks	Partially Met
Pt will demonstrate ability to perform all upper body dressing tasks without difficulty or pain in 6 weeks	Met
Pt will increase L shoulder AROM to at least 150 degrees of scaption in 6 weeks	Not Met
Pt will be able to perform all normal work related tasks without pain or difficulty in 8 weeks	Not Met
Pt will be able to reach overhead into elevated cabinets without increase in pain in 8 weeks	Partially Met
Pt will tolerate at least 30 min continuous sitting activity without increase in low back pain in 6 weeks	Not Met
Pt will report uninterrupted sleep from low back pain in 4 weeks	Partially Met

**New Goals**

--	--

**PLAN:** Pt to continue PT on Left shoulder for remaining two visits. PT recommends continued therapy on left shoulder for 2x/week for 4 more weeks or until patient returns to MD in March for RUE follow-up. MD reports to hold off on RUE PROM and therapy at this time until further follow up.

This note has been electronically signed by **Kyle Todd PT**

FROM

(WED) MAR 19 2014 20:16/ST. 20:12/No. 6814013655 P 11

Patient: Arthur C Davis

DOB: [REDACTED]

Date of Note: 02-13-2014

STAR account#: 4. 198

Page 3 of 4

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues to be on hold for PT

TIME IN:

TIME OUT:

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		22
Functional activities*		10
Manual therapy tech*		22
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	22 min to L shoulder	
Lumbar paraspinal STM		
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each	
Tband IR	BTB 3 x 15 each	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#3lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x 10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #15	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	HOLD- may attempt LLE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	
Table slides ER	5 min	

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FROM

(WED) MAR 19 2014 20:16/ST. 20:12/No. 6814013655 P 12

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 02-13-2014

STAR account#: 4. /98

Page 4 of 4

**Total Treatment Time: 54 minutes**

*This note has been electronically signed by **Kyle Todd PT***

Murfreesboro 1725 Medical Center Pkwy, Ste 130 Murfreesboro, TN 37129-2248 Phone: 615-217-0259, FAX: 615-217-1290

DCN: 140320054758 PAGE: 023 SEQUENCE: SWF0320201400721001

Case 1:15-cv-00086 Document 13-1 Filed 02/18/16 Page 674 of 1151 Page 674 of 1151



## DAILY TREATMENT NOTE

Date of Note: 02-21-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49

Rotator Cuff Tear (traumatic) 840.4

Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 01-31-14

**SUBJECTIVE:** Pt brought in new script for PROM to R shoulder today. Pt reports elevation above left shoulder continues to feel tight and difficult to perform ADL's above shoulder height. Pt reports no change in RUE due to surgical precautions of PROM only.

**Pain/Symptom Level:**

**OBJECTIVE:** See measurements below. Progressed treatment to include PROM and joint mobs to Right shoulder. Held on RUE exercises today due to surgical precautions to RUE. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Diagnosis/anatomy/healing process education, HEP instruction and Surgical precautions.

Test	Test Description	Current Results	Previous Results	Comments
Posture - Trunk / Lower Qtr.	Lordosis	WNL	WNL	
Shoulder - AROM	Shoulder Flexion (L)	140 Degrees	138 Degrees	
	Shoulder Abduction (L)	98 Degrees	95 Degrees	
	Functional Reach Internal Rotation (L)	T10	T10	
	Functional Reach External Rotation (L)	T6	T6	
	Shoulder Scaption with Functional ER	145 Degrees	145 Degrees	
	Shoulder Flexion (R)	NPT		
	Shoulder Abduction (R)	NPT		
	Functional Reach Internal Rotation (R)	NPT		
	Functional Reach External Rotation (R)	NPT		
Shoulder - PROM	Shoulder Flexion (L)	163 Degrees	160 Degrees	
	Shoulder Abduction (L)	145 Degrees	140 Degrees	
	Shoulder External Rotation (L)	88 Degrees	80 Degrees	
	Shoulder Internal Rotation (L)	62 Degrees	60 Degrees	
	Shoulder PROM (L)	Min. limited	Min. limited	
	Shoulder Flexion (R)	135	NPT	
	Shoulder Abduction (R)	110	NPT	
	Shoulder External Rotation (R)	70	NPT	
	Shoulder Internal Rotation (R)	45	NPT	
Shoulder - Strength	Shoulder Flexion (R)	NPT		
	Shoulder Abduction (R)	NPT		
	Shoulder External Rotation (R)	NPT		
	Shoulder Internal Rotation (R)	NPT		

Murfreesboro 1725 Medical Center Pkwy, Ste 130 Murfreesboro, TN 37129-2248 Phone: 615-217-0258, FAX: 615-217-1290

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 02-21-2014

STAR account#: 4. /98

Page 2 of 4

Rotation (R)			
Shoulder Flexion (L)	4/5		
Shoulder Abduction (L)	4/5		
Shoulder External Rotation (L)	4-/5		
Shoulder Internal Rotation (L)	4-/5		

**ASSESSMENT:** Pt tolerated treatment well today. Pt able to demonstrate increased PROM of LUE with continued tightness at end range in all planes. Pt able to demonstrate good PROM of RUE for first visit for therapy on RUE. Pt continues to increase strength in LUE, through elevation activities continue to be difficult. Pt continues to demonstrate mild compensation of left shoulder with elevation activities. Pt will continue to benefit from skilled PT for LUE and RUE shoulders due to decreased ROM and weakness.

**Current Goals****Outcome**

Pt will report less than 3/10 pain in 2 weeks at rest	Partially Met
Pt to be instructed in HEP	Met
Pt will demonstrate improved postural awareness in 2 weeks evidenced by PT observation of movement patterns in clinic	Met
Pt will improve L shoulder flexion and ER Muscle strength to 4+/5 in 6 weeks	Partially Met
Pt will report no more than 2/10 pain at worst in 4 weeks	Partially Met
Pt will demonstrate ability to perform all upper body dressing tasks without difficulty or pain in 6 weeks	Met
Pt will increase L shoulder AROM to at least 150 degrees of scaption in 6 weeks	Not Met
Pt will be able to perform all normal work related tasks without pain or difficulty in 8 weeks	Not Met
Pt will be able to reach overhead into elevated cabinets without increase in pain in 8 weeks	Partially Met
Pt will tolerate at least 30 min continuous sitting activity without increase in low back pain in 6 weeks	Not Met
Pt will report uninterrupted sleep from low back pain in 4 weeks	Partially Met

**New Goals**

Pt will increase PROM of RUE to 160° flexion/scaption, 90 ER, 60 IR within 4 weeks
Pt will be knowledgeable of surgical precautions of RUE within 2 weeks
Pt will increase PROM to WNL within 6 weeks

**PLAN:** Continue progression per protocol.

*This note has been electronically signed by Kyle Todd PT*



FROM

(WED) MAR 19 2014 20:17/ST. 20:12/No. 6814013655 P 15

Patient: Arthur C Davis

DOB: REDACTED

Date of Note: 02-21-2014

STAR account#: 4.198

Page 3 of 4

**PRECAUTIONS/CONTRAINDICATIONS:** RUE continues to be on hold for PT

TIME IN: 10:55AM

TIME OUT: 12:00PM

Treatment/Exercise	Results/Measurements	Minutes
Physical therapy evaluation		
Therapeutic exercise*		23
Functional activities*		12
Manual therapy tech*		30
Electrical stim. (unatt.)	IFC 80-120 hz with moist heat to lumbar paraspinals-during manual therapy	
Timed code minutes*		
PT 30 Day Reassessment Due:		
Involved Extremity	L shoulder and Low back Pain --Multi Diagnosis--	
*** MANUAL THERAPY ***		
PROM with gr I and II joint mobilizations	15 min to RUE and LUE	
Lumbar p/a mobs		
Lumbar rotational mobilizations		
*** THERAPEUTIC EXERCISES ***		
Recumbent cycle	D/C	
Pendulums		
SKTC	NPT	
DKTC		
LTR	NPT	
PPT		
SB press single arm in supine		
SB LE rollouts		
Supine hip abduction		
Pulleys	HOLD	
Table slides	DC for functional reaching	
Wall walks	30x flexion and abduction	
Scap squeezes	D/C	
Tband Rows/SAP	HOLD	
Tband ER	BTB 3 x 15 each	
Tband IR	BTB 3 x 15 each	
Supine Cane flexion		
Standing Cane flexion	HOLD	
Standing Cane ER for AAROM	HOLD	
Seated SB marching/LAQ		
Supine Hip abduction with abdom brace	NPT	
Supine shld protraction (serratus punches)	#3lbs 3 x 10	
Supine shld flexion AROM in pain free range	#1lbs 3 x 10	
S/L ER	HOLD	
Prone rowing	HOLD	
Prone extension	HOLD	
standing flexion	2 x10 fatigued easily	
CC Machine Rows/Saps Single UE	3 x 10 #15	
*** FUNCTIONAL ACTIVITIES ***		
Pt education		
UBE	8 min with LUE only	
SB wall roll ups for reaching simulation	HOLD	
Table slides for reaching simulation	5 in scaption	
Wall Washes	HOLD	
Table slides ER	5 min- npt	

Murfreesboro 1725 Medical Center Pkwy, Ste 130 Murfreesboro, TN 37129-2248 Phone: 615-217-0259, FAX: 615-217-1290

DCN: 140320054758 PAGE: 029 SEQUENCE: SWF0320201400721001

FROM

(WED) MAR 19 2014 20:17/ST. 20:12/No. 6814013655 P 16

Patient: Arthur C Davis

DOB:

REDACTED

Date of Note: 02-21-2014

STAR account#: 4. .798

Page 4 of 4

**Total Treatment Time:** 65 minutes

*This note has been electronically signed by Kyle Todd PT*

FROM

(WED) MAR 19 2014 20:17/ST. 20:12/No. 6814013655 P 17



## DAILY TREATMENT NOTE

Date of Note: 02-25-14

PATIENT NAME: Arthur C Davis

PATIENT DOB: REDACTED

STAR Account #: 474798

PHYSICIAN: R James Renfro Jr MD

DIAGNOSIS: Other specified aftercare following surgery V58.49 Rotator Cuff Tear (traumatic) 840.4  
Shoulder Pain 719.41 Shoulder Stiffness 719.51

Next MD Visit: 03-11-14

**SUBJECTIVE:** Pt reports he didn't take any tylenol this morning and is having more pain "all over". Pt states his R shoulder is feeling "really good"

**Pain/Symptom Level:**

**OBJECTIVE:** Progressed treatment per activity flowsheet. The following procedures were performed at distinctly different time intervals from each other: functional activities and manual techniques. Pt received education on the following: Diagnosis/anatomy/healing process education.

Test	Test Description	Current Results	Previous Results	Comments

DCN: 140320054758 PAGE: 033 SEQUENCE: SWF0320201400721001

03/19/2014 12:57

**AUTHORIZATION FOR RELEASE  
OF INFORMATION**I, Arthur Davis, hereby authorize Dr. Cote, D.O.

(address &amp; telephone number)

(the "Practice") to disclose health information regarding the below referenced patient.

Patient Name: Arthur DavisDate of Birth: REDACTEDAddress: REDACTEDPhone #: REDACTEDMurfreesboro, TN 37128

Name of person/organization records to be disclosed to:

Aetnaph # 954-193-2140fax # 860-907-4494**This authorization will  
EXPIRE on 9.19.14.**Specific description of information (including date(s)): All medical recordsPurpose of the use or disclosure: ☒ At the request of the individual ☐ Insurance not accepted by MMC ☐ Changing Doctor ☐ Moving  
☐ Physician/Staff Request ☐ Marketing\* ☐ Sale of Information\* ☐ Other :

\*If the use or disclosure for which authorization is being sought is for marketing purposes, the use or disclosure ( ) will ( ) will not) result in direct or indirect financial remuneration to us from someone else. If we are seeking your authorization to sell your information, the disclosure will result in remuneration to us from someone else.

I understand that I may revoke this authorization at any time by sending a written request to the Practice - Attn: Privacy Officer. However, the revocation will not have any effect on any uses or disclosures the Practice may have made before the revocation was received.

I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) months after the date this authorization is signed.

I understand that I may refuse to sign this authorization and that the Practice will not condition treatment on whether or not I sign this authorization.

I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

I understand that the information in my health record may include information about behavioral or mental health services, treatment for alcohol and drug abuse, or information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

I certify that I am (check whichever applies):

☒ the patient.☐ the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of \_\_\_\_\_Signature: Arthur DavisDate: 3/19/14

If signature is not that of patient:

Print name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**\*\* A COPY OF THIS AUTHORIZATION SHOULD BE RETAINED BY THE PATIENT \*\***Date Revd: \_\_\_\_\_  
Date Processed: \_\_\_\_\_  
Processed by: \_\_\_\_\_Murfreesboro Medical Clinic & SurgiCenter  
Medical Records Department - Fax 615.867.7926  
1272 Garrison Drive, Murfreesboro, TN 37129  
615.867.7917 • 800.842.6692 • www.mmclinic.com

Revised - March 2014



## Fax Message

---

**To:** medical records

**Fax:** 8666671987

**From:** Amor, Maribel

**Date:** 2014-03-19 3:42 PM

**Pages:** 1 of 20 (including this page)

**Subject:** Arthur Davis, claim 9452367

---

**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

*Maribel Amor, MST  
Senior Disability Benefit Manager  
Aetna Life Insurance Company  
Ph: 954-693-2140  
Fax: 860-907-4494  
E-mail: AmorM@Aetna.com*

03/19/2014 12:57

(FAX)

P.002/018

Page 1 of 1

Premier  
Radiology  
MURFREESBORO



Saint Thomas  
Health

Premier Radiology Murfreesboro  
1840 Medical Center Parkway, Suite 101  
Murfreesboro, TN 37129  
Phone #: (615)896-1234  
Fax: (615)234-1504

Name: ARTHUR DAVIS  
Patient ID: 1000977943  
Secondary ID:  
DOB: **REDACTED**  
Acc #: 3338109

Exam Date: 11/06/2013 04:17 PM  
Exam Name: MR Lumbar spine w/o contrast | 72148  
Referrer: Christopher Kauffman, MD  
2nd Referrer:

PROCEDURE: MRI LUMBAR SPINE WITHOUT CONTRAST

TECHNIQUE: Magnetic resonance imaging of the lumbar spine was performed using standard pulse sequences without contrast material. CPT 72148

HISTORY: Sclatica CENTER LOWER BACK PAIN.

COMPARISONS: None .

FINDINGS:

The vertebral body heights are well maintained. No subluxation is present. There is no abnormal marrow signal. The conus tip is located at L1-L2. The conus and filum terminale are normal in appearance. No paravertebral soft tissue abnormalities are present. Disc desiccation and mild intervertebral disc height loss at L3-L4.

L1-L2: Mild broad-based posterior disc bulge with no spinal canal stenosis or neuroforaminal narrowing.

L2-L3: Mild broad-based posterior disc bulge with no spinal canal stenosis or neuroforaminal narrowing.

L3-L4: Broad-based posterior disc bulge with facet joint and ligamentum flavum hypertrophy. No spinal canal stenosis or significant neuroforaminal narrowing.

L4-L5: Broad-based posterior disc bulge with facet joint and ligamentum flavum hypertrophy. No significant spinal canal stenosis. Mild RIGHT neural foraminal narrowing noted.

L5-S1: Mild broad-based posterior disc bulge with facet joint and ligamentum flavum hypertrophy. No spinal canal stenosis or RIGHT neural foraminal narrowing. There is mild LEFT neuroforaminal narrowing.

IMPRESSION:

1. Multilevel disc bulges with no spinal canal stenosis.
2. Multilevel facet joint/ligamentum flavum hypertrophy, with mild RIGHT neural foraminal narrowing at L4-L5 and mild LEFT neural foraminal narrowing at L5-S1.
3. Mild degenerative disc disease at L3-L4.

ws:MTISTN-READING0

Electronically Signed by: Eric Dame M.D.  
Electronically Signed on: 11/06/2013 11/6/2013 4:26:52 PM

.Reviewed by: NICHOLAS COTE D.O. Jan 23 2014 1:06PM CST 1/23/2014

<https://ris.premierradiology.com/Reports/printReportCustom.aspx?acc=3338109>

12/27/2013

DCN: 140319086633 PAGE: 007 SEQUENCE: SWF0319201404074001

Case 1:15-cv-00086 Document 13-1 Filed 02/18/16 Page 683 of 1151 Page ID #: 327

03/19/2014 12:58  
 Progress Note] [ARTHUR DAVIS, JR.] [08/103]

(FAX)

P.003/018  
 [1/9/2014] Page 1 of 4

## Progress Note

**Patient Name:** Arthur Davis, Jr.  
**Patient ID:** 687103  
**Sex:** Male  
**Birthdate:** REDACTED  
**Primary Care Provider:** Tadayuki Yoneyama MD  
**Referring Provider:** Former Patient  
**Visit Date:** December 19, 2013  
**Provider:** Christopher P. Kauffman, MD  
**Location:** Harding Place  
**Location Address:** 394 Harding Place Suite 200  
 Nashville, TN 372113980  
**Location Phone:** (615) 834-4482

### Chief Complaint

- Back pain

482122

### History Of Present Illness

The patient is a 50 year old Black/African American male who returns for a follow up visit for low back pain.

The low back pain developed acutely on 09/27/2013. It is 6/10 in severity, has an aching, a sharp, and shooting quality and radiates into the right posterior leg in a nonspecific and lower leg in a nonspecific distribution. The pain has been constant and has been progressively worsening. The onset was associated with a motor vehicle accident. The pain tends to be maximal at night and the pain interferes with sleep. The patient states the pain is aggravated by bending and prolonged standing. It is alleviated by changing position.

He denies urinary incontinence and fecal incontinence.

The patient has no prior history of neck or back surgery.

#### **RECENT INTERVENTIONS:**

He has been previously treated with physical therapy, NSAIDs, pain medication, and bedrest. The physical therapy was partially effective in relieving the pain.

#### **INFORMATION REVIEWED:**

The following information was reviewed: radiology reports and images. The MRI of the lumbar spine revealed degenerative disk disease and facet arthropathy. The degenerative disc disease is present at L3/4 level(s) on the bilaterally. The facet arthropathy is present at L4/5 and L5/S1 on the bilaterally. The herniated DISC/DISCS seen at L5-S1 on the right.

The patient reports that his back pain has stabilized. Patient initially thought that the physical therapy was not helpful but he has since noted that he has had improvement in his pain during the day.

The patient reports main problem he has with back pain is at night.

I asked the patient to try taking Neurontin 3 mg at night but he reports that he did not fill the prescription.

I gone over what I thought that Neurontin would possibly help with her and discussed this with the patient after answering all his questions patient is amenable to trying medication at this time.

Patient reports the still out of work secondary problems with his shoulders. The

### Last Medical History

Disease Name	Date Onset	Notes
Asthma	--	--
Degeneration of lumbar intervertebral disc	11/07/2013	--
High blood pressure	--	--
Rotator Cuff Sprain/Tear	10/07/2013	--
Rotator Cuff Tear, Non-Trauma	10/07/2013	--
Sciatica	11/02/2013	--
Sprain/Strain	10/18/2013	--
Sprain/Strain, Lumbar	10/18/2013	--

### Last Surgical History

Reviewed by: NICHOLAS COTE D.O. Jan 23 2014 1:06PM CST 1/23/2014

[Digital Signature Validated]



03/19/2014 12:58  
Progress Note] [Arthur Davis, Jr.] [68/103]

(FAX)

P.004/018  
[1/9/2014] Page 2 of 4

Procedure Name	Date	Notes
Hernia	--	--
Joint surgery (arthroscopic or open)	2004	left knee
Sinus Surgery	--	--

**Medication List**

Name	Date Started	Instructions
Advair Diskus Inhalation disk w/ device 250-50 mcg/dose	07/19/2013	--
amlodipine Oral tablet 10 mg	09/10/2013	--
Celebrex Oral capsule 200 mg	07/12/2013	--
ciprofloxacin Oral tablet 500 mg	07/11/2013	--
clotrimazole-betamethasone Topical cream 1-0.05 %	08/13/2013	--
fluticasone Nasal spray,suspension 50 mcg/actuation	07/19/2013	--
lisinopril-hydrochlorothiazide Oral tablet 20-25 mg	09/23/2013	--
methylprednisolone Oral tablets,dose pack 4 mg	09/19/2013	--
metoprolol succinate Oral tablet extended release 24 hr 50 mg	07/31/2013	--
naproxen Oral tablet 500 mg	09/27/2013	--
Neurontin oral capsule 300 mg	12/19/2013	1 capsule (300 mg) by oral route every eight hours for 30 days
omeprazole Oral capsule,delayed release(DR/EC) 20 mg	07/19/2013	--
potassium chloride Oral tablet extended release 10 mEq	08/06/2013	--
prednisone Oral tablet 20 mg	09/27/2013	--
spironolactone Oral tablet 25 mg	08/13/2013	--
Ultram Oral tablet 50 mg	11/06/2013	take 1 tablet (50 mg) by oral route every 6 hours as needed for 15 days

**Allergy List**

Allergen Name	Date	Reaction	Notes
codeine sulfate	--	itching/rash	--

**Family Medical History**

Disease Name	Relative/Age	Notes
Family history of arthritis	/	--
	Mother/	
Family history of heart disease	/	--
	Mother/	

**Social History**

Finding	Status	Start/Stop	Quantity	Notes
Alcohol Intake	Never	--/--	--	--
Tobacco	Never	--/--	--	--

**Review of Systems**

Constitutional

[Digital Signature Validated]

03/19/2014 12:58

(FAX)

P.005/018

Progress Note] [Arthur Davis, Jr.] [687103]

[1/9/2014] Page 3 of 4

- o Denies : fever, chills, weight loss

**Eyes**

- o Denies : discharge from eye, impaired vision, changes in vision

**EENT**

- o Denies : headaches, vertigo, lightheadedness, sore throat

**Breasts**

- o Denies : lumps, tenderness, nipple discharge

**Cardiovascular**

- o Denies : chest pain, rapid heart rate

**Respiratory**

- o Denies : shortness of breath, cough

**Gastrointestinal**

- o Denies : nausea, vomiting, diarrhea, constipation, blood in stools

**Genitourinary**

- o Denies : urgency, frequency, dysuria

**Integument**

- o Denies : rash, itching

**Neurologic**

- o Admits : sciatica

- o Denies : muscular weakness, incoordination, loss of balance

**Musculoskeletal**

- o Admits : back pain

**Endocrine**

- o Denies : polyuria, polydipsia, constipation, cold intolerance

**Psychiatric**

- o Denies : anxiety, depression

**Heme-Lymph**

- o Denies : easy bleeding, easy bruising, lymph node enlargement or tenderness

**Allergic-Immunologic**

- o Denies : allergic dermatitis, frequent illnesses

All Others Negative

**Physical Examination****Constitutional**

- o Appearance : well-nourished, well developed, alert, in no acute distress

**Thoracic Spine**

- o Inspection : no lesions or deformities, paraspinal musculature is nontender to palpation

- o Thoracic Spine Range of Motion : full ROM

- o Muscle Strength/Tone/Bulk : paraspinal muscle strength within normal limits

**Lumbosacral Spine**

- o Inspection : no lesions or deformities, paraspinal musculature is nontender to palpation

- o Palpation : paraspinal musculature is nontender to palpation

- o Stability : no subluxations present

- o Range of Motion : *mildly reduced ROM-active flexion*

- o Muscle Strength : paraspinal muscle strength and tone within normal limits

- o Muscle Tone : paraspinal muscle tone within normal limits

- o Muscle Bulk : no muscle atrophy

- o Tests/Signs : straight leg raise test negative bilaterally

**Right Lower Extremity**

- o Musculoskeletal Examination : examination of the hip, thigh, knee, lower leg, ankle and foot revealed no tenderness, swelling, deformities, instability, subluxations, weakness, or atrophy. Range of motion in all planes was full and painless.

- o Muscle Tone : tone normal, no atrophy

- o Muscle Bulk : normal muscle bulk present

- o Skin : no erythema present, no ecchymosis present

- o Sensation : right lower extremity neurologically intact

- o Reflexes : patellar tendon reflex 2+, ankle reflex 2+

- o Vascular Exam : dorsalis pedis artery pulse 2+, posterior tibial artery pulse 2+, capillary refill normal

**Left Lower Extremity**

- o Musculoskeletal Examination : examination of the hip, thigh, knee, lower leg, ankle and foot revealed no tenderness, swelling, deformities, instability, subluxations, weakness, or atrophy. Range of motion in all planes was full and

[Digital Signature Validated]

03/19/2014 12:58  
Progress Note] [Arthur Davis, Jr.] [687103]

(FAX)

P.006/018  
[1/9/2014] Page 4 of 4

painless:

- o **Muscle Tone** : tone normal
- o **Muscle Bulk** : normal muscle bulk present
- o **Skin** : no erythema present, no ecchymosis present
- o **Sensation** : left lower extremity neurologically intact
- o **Reflexes** : patellar tendon reflex 2+, ankle reflex 2+
- o **Vascular Exam** : dorsalis pedis artery pulse 2+, posterior tibial artery pulse 2+, capillary refill normal

**Gait and Station**

- o **Gait** : normal gait, able to stand without difficulty

**Assessment**

- Degeneration of lumbar intervertebral disc 722.52
- Lumbago (LBP) 724.2

**Plan**

**Instructions**

- o The patient wishes a referral to physical therapy.
- o Return to clinic after Physical Therapy Consult and modalities.
- o Start Gabapentin. I have asked the patient to start just taking gabapentin at night for the first 2 days. Then take the medication twice daily. If the patient does not have any side effects then progressed to 3 times daily. Potential side effects of dizziness and swelling of the legs have been discussed
- o Patient with low back pain secondary to degenerative changes and facet arthropathy. Patient's back pain during the day has stabilized. The rest patient to continue with his physical therapy regimen and continue with his home exercise program. Patient is amenable to trying gabapentin at night. Patient will try this medication and follow up with us by phone. He reports that he had shoulder surgery on his other shoulder so I will let him rescheduled us as needed following his shoulder surgery.

**Disposition**

- o Call or Return if symptoms worsen or persist.

Electronically Signed by: Christopher P. Kauffman, MD -Author on December 19, 2013 04:47:15 PM

[Digital Signature Validated]

03/19/2014 12:58

(FAX)

**Murfreesboro Medical Clinic**

1272 Garrison Drive  
Murfreesboro, TN 37129  
615-867-8010 www.mmclinic.com 1-800-842-6692

**Department of Internal and Family Medicine****Patient Name: ARTHUR C. DAVIS****Chart # 482122****Encounter Date: 01/16/2014****Visit Summary****Patient Details of ARTHUR DAVIS****Contact** ARTHUR DAVIS**Date Of Birth****REDACTED****Address****REDACTED****Gender**

Male

MURFREESBORO, TN 371286537

**Marital Status**

D

**REDACTED****Language**

English - preferred

- ◆ Lower Back Pain
- ◆ Benign Essential Hypertension
- ◆ Esophageal Reflux
- ◆ Intervertebral Disc Degeneration

Date	Description	Test	Result
16 Jan 2014 08:29 AM	recorded by: Vance, Christy	BP Systolic	126 mm[Hg]
		BP Diastolic	82 mm[Hg]
		Heart Rate	82 /min
		Body Mass Index Calculated	32.37
		Body Surface Area Calculated	2.3
		Height	72 in
		Weight	239 lb
		O2 SAT	98 %

1 of 2

03/19/2014 12:58

(FAX)

P.008/018

- ◆ Potassium Chloride ER 10 MEQ Oral Tablet Extended Release; ; Days: 30; Qty: 60; Refill: 0 (Active)
- ◆ Advair Diskus 250-50 MCG/DOSE Inhalation Aerosol Powder Breath Activated; ; Days: 90; Qty: 180; Refill: 0 (Active)
- ◆ CeleBREX 200 MG Oral Capsule; ; Days: 90; Qty: 90; Refill: 0 (Active)
- ◆ Lisinopril-Hydrochlorothiazide 20-25 MG Oral Tablet; ; Days: 90; Qty: 90; Refill: 0 (Active)

- ◆ Somatic Dysfunction Of Sacroiliac Region (Active)
- ◆ Lower Back Pain (Active)
- ◆ Benign Essential Hypertension (Active)
- ◆ Esophageal Reflux (Active)
- ◆ Intervertebral Disc Degeneration (Active)
- ◆ Asthma (Active)

- ◆ OxyCODONE HCl CAPS (Active)

- ◆ COTE,NICHOLAS 01/28/2014 10:30:00 AM
- ◆ LAB MMC,LAB 02/27/2014 12:15:00 PM
- ◆ COTE,NICHOLAS 03/06/2014 9:30:00 AM

Ambulatory Health      NICHOLAS COTE , D.O.  
 Care Facilities      1272 Garrison Drive  
                              Murfreesboro, TN 37129  
                              (615)893-4480 (Work phone)

	SUMMARIZATION OF EPISODE NOTE	Encounter	January 16, 2014 08:00+0000
From	Enterprise EHR 11.203.4482.15631; Transform 3.2.0.23	Site	Murfreesboro Medical Clinic and SurgiCenter 1272 Garrison Drive Murfreesboro, TN 37129 (615)893-4480 (Work phone)
Created	January 16, 2014 09:11-0600	By	NICHOLAS COTE , D.O.

03/19/2014 12:59

(FAX)

P.009/018

results PHYSIOTHERAPY Fax: 615-896-6825

Jan 21 2014 06:16am

P002/003



results physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: **REDACTED**  
Physician: Nicholas Cote MD  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
PSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Visit Date: Jan 20, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 1  
Cxl/Ns: 0  
Employer: DISABILITY  
Insured:

## Plan of Care

A82128

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

### Assessment

Pt present with irritable low back/sacral pain impacting ADL's (working, sitting, standing etc.). Unable to assess joint mobility at time of eval secondary to muscle guarding. Pt would benefit from skilled PT services to address functional return to ADL's.

Treatment Emphasis to focus on: Maximizing function related to:

- ADL's. Work performance.

### Problems & Goals

**Problem #1 Chief Complaint:** Pain: Current Severity: 8/10.

LTG Achieve by Feb 17, 2014.

**Symptomatic Improvements:**

- Decreasing Pain: to 3/10.

**Problem #2 Questionnaires:** Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient.

- Score 38

LTG Achieve by Feb 17, 2014.

**Questionnaire Improvements:** Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Follow Up: Patient:

- Score 50

**Problem #3 Client Knowledge/Awareness of:** Home Exercise Program: Lacks appropriate program.

STG Achieve by Feb 03, 2014.

**Client Education:**

- Independent Home Exercise/Self Care Program.

**Problem #4 Range of Motion: Spine: Pre-Treatment: Active Lumbosacral.**

- Extension 50%
- Flexion(increased pain) 75%
- Side Bending Left 75%
- Side Bending Right(most pain) 75%

LTG Achieve by Feb 17, 2014.

**Range of Motion Improvements to: Active Lumbosacral:**

- Gross Assessment WNL

**Problem #5 Palpaton: Lumbosacral Region: Musculature,**

**Posterior: Guarding.**

- Gluteus Maximus

- Piriformis

- Quadratus Lumborum

Left

Severe

Severe

Severe

Right

Severe

Severe

Severe

LTG Achieve by Feb 17, 2014. to improve sitting tolerance.

**Palpable Improvements:**

- Guarding Decreasing to: Moderate Levels.

**Problem #6 Observations:** Pt able to sit <1 minutes before position changed required secondary to pain.

LTG Achieve by Feb 17, 2014. to improve sitting tolerance.

Document ID: 0070090B.002

Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2

03/19/2014 12:59

(FAX)

P.010/018

results PHYSIOTHERAPY Fax: 615-896-8825

Jan 21 2014 06:16am

P003/003

Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Jan 20, 2014

**Functional Test Improvements:**

- Pt to sit >=10 minutes before needing position change.

**Plan****Amount, Frequency and Duration:**

- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 3 visits a week with an expected duration of 6 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

**Therapeutic Contents:**

- Client Education. Gait Training. Home Exercise Program. Joint Mobilization Techniques. Manual Therapy Techniques. Modalities: As Needed. Therapeutic Activities. Therapeutic Exercise.
- Additional:
  - Brace/Tape/Splint: Tape. Trigger Point Dry Needling

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886), DPT

Signed on Jan 20, 2014 12:35:10

**Please sign and return**

I have reviewed this Plan of Care and certify that the skilled therapy services identified are required to meet the patient's need.  
Comments and/or revisions to this Plan of Care are noted below.

Comments/Revisions

Nicholas Cote MD DO

Date

1/23/14

Document ID: 0070090B.002  
Lakota C. Hillis, PT(TN Lic: 8886), DPT

Status: Signed off (secure electronic signature)

Page 2 of 2

03/19/2014 12:59

(FAX)

P.011/018

**Murfreesboro Medical Clinic**

1272 Garrison Drive  
Murfreesboro, TN 37129  
615-867-8010 www.mmcclinic.com 1-800-842-6692

**Department of Internal and Family Medicine****Patient Name: ARTHUR C. DAVIS****Chart # 482122****Encounter Date: 01/28/2014****Visit Summary****Patient Detail for ARTHUR DAVIS**

<b>Contact</b>	ARTHUR DAVIS	<b>Date Of Birth</b>	REDACTED
<b>Address</b>	REDACTED	<b>Gender</b>	Male
	MURFREESBORO, TN 371286537	<b>Marital Status</b>	D

**REDACTED****Language** English - preferred

Date	Description	Test	Result
28 Jan 2014 10:51 AM	recorded by: Vance, Christy	BP Systolic	124 mm[Hg]
		BP Diastolic	80 mm[Hg]
		Heart Rate	83 /min
		Body Mass Index Calculated	32.91
		Body Surface Area Calculated	2.32
		Weight	243 lb
		O2 SAT	98 %

**Medication**

- ◆ Potassium Chloride ER 10 MEQ Oral Tablet Extended Release; ; Days: 30; Qty: 60; Refill: 0 (Active)
- ◆ Advair Diskus 250-50 MCG/DOSE Inhalation Aerosol Powder Breath Activated; ; Days: 90; Qty: 180; Refill: 0 (Active)
- ◆ CeleBREX 200 MG Oral Capsule; ; Days: 90; Qty: 90; Refill: 0 (Active)
- ◆ Lisinopril-Hydrochlorothiazide 20-25 MG Oral Tablet; ; Days: 90; Qty: 90; Refill: 0 (Active)
- ◆ Amlodipine Besylate 10 MG Oral Tablet; ; Days: 0; Qty: ; Refill: 0 (Active)
- ◆ Omeprazole 20 MG Oral Tablet Delayed Release; ; Days: 0; Qty: ; Refill: 0 (Active)
- ◆ Flonase 50 MCG/ACT Nasal Suspension; ; Days: 0; Qty: ; Refill: 0 (Active)

1 of 2



03/19/2014 12:59

(FAX)

P.012/018

◆ Spironolactone 25 MG Oral Tablet; ; Days: 0; Qty: ; Refill: 0 (Active)

- ◆ Lower Back Pain (Active)
- ◆ Benign Essential Hypertension (Active)
- ◆ Esophageal Reflux (Active)
- ◆ Intervertebral Disc Degeneration (Active)
- ◆ Somatic Dysfunction Of Sacroiliac Region (Active)
- ◆ Asthma (Active)

◆ OxyCODONE HCl CAPS; Reactions: Itching (Active)

- ◆ KATTINE,ALBERT 02/06/2014 8:45:00 AM
- ◆ LAB MMC,LAB 02/27/2014 12:15:00 PM
- ◆ COTE,NICHOLAS 03/06/2014 9:30:00 AM

Ambulatory Health Care Facilities      NICHOLAS COTE , D.O.  
1272 Garrison Drive  
Murfreesboro, TN 37129  
(615)893-4480 (Work phone)

## SUMMARIZATION OF EPISODE NOTE

	<b>Encounter</b>	January 28, 2014 10:30+0000
<b>From</b>	<b>Site</b>	Murfreesboro Medical Clinic and SurgCenter 1272 Garrison Drive Murfreesboro, TN 37129 (615)893-4480 (Work phone)
<b>Created</b>	<b>By</b>	NICHOLAS COTE , D.O.

03/19/2014 12:59

(FAX)

P.013/018



results PHYSIOTHERAPY  
 520 Highland Terrace, Suite A  
 Murfreesboro, TN USA  
 37130-2496  
 Phone: (615) 896-6866  
 Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825  
 Patient: ARTHUR DAVIS  
 Acct #: 124961  
 DOB: REDACTED  
 Physician: Nicholas Cote DO  
 Phys Fax: (615) 867-7945  
 Physician: Not Specified  
 Clinician: Lakota C. Hillis  
 PSC: Commercial Insurance  
 Case Mgr:  
 Payer: AETNA  
 Pol/Claim#:

Feb 10 2014 11:37am

P002/003

482122

Note Date: Feb 10, 2014  
 Phys Phone: (615) 867-8010  
 SSN: XXX-XX-XXXX  
 Inj. Date: Jan 20, 2014  
 Surg. Date:  
 Visits: 9  
 Cx/INs: 0  
 Employer: DELL  
 Insured:

## Progress Note

**Diagnoses** Spine 7242 LUMBAGO  
 7197 DIFFICULTY IN WALKING

### Subjective Examination

#### Chief Complaint:

- Pain; Current Severity: 6/10.

#### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

Questionnaires: Focus on Therapeutic Outcomes (FOTO); Physical Functional Status Measure: Intake: Patient:  
 • Score 38

### Objective Examination

#### Observations:

- Pt able to sit 8 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:**

#### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

**Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:**

- Extension
- Flexion (increased pain)
- Side Bending Left
- Side Bending Right

**Range of Motion: Spine: Post-Treatment: Active Lumbosacral:**

- Extension
- Flexion

Left

Mild  
Mild  
Mild

Jun 20, 2014

50%  
75%  
75%  
75%

Right

Mild  
Mild  
Mild

Feb 10, 2014

100%  
100%  
100%  
100%  
Feb 10, 2014  
100%  
100%

### Assessment

Pt with continued high subjective c/o pain but improved endurance, lumbar ROM and decreased muscle guarding overall. Will continue to progress as tolerated.

### Plan

#### Daily Plan:

- Continue w/ Current Rehabilitation Program.

Document ID: 00700908.011  
 Lakota C. Hillis, PT (TN Lic: 8886), DPT

Status: Signed off (secure electronic signature)

Page 1 of 2

03/19/2014 13:00

(FAX)

P.014/018

results PHYSIOTHERAPY Fax:615-896-6825

Feb 10 2014 11:37am

P003/003

Patient: ARTHUR DAVIS  
Acct #: 124961

Note Date: Feb 10, 2014

**Therapy  
Referral**

- I have read the above report and request that my patient:
- ☐ Continue with treatment program as indicated above.
  - ☒ Continue treatment program for 3 days/week for 5 weeks.
  - ☐ Revise treatment program as indicated: \_\_\_\_\_
  - ☐ Progress to a home exercise program.
  - ☐ Be discharged.
  - ☐ Other: \_\_\_\_\_

Electronically authenticated.

Please sign  
and return

---

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Feb 10, 2014 12:18:21  
Nicholas Cote DO2/21/14  
DateDocument ID: 0070090B.011  
Lakota C. Hillis, PT(TN Lic: 8886), DPT

Status: Signed off (secure electronic signature)

Page 2 of 2

03/19/2014 13:00

(FAX)

P.015/018

Mar 4 2014 11:52am

P002/003



results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: (24961  
DOB: REDACTED  
Physician: Nicholas Cole DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
PSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Note Date: Mar 04, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 18  
Cxl/Ns: 1

Employer: DELL  
Insured:

## Progress Note

482122

**Diagnoses** Spino 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 0/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:

- Score 48

## Objective Examination

### Observations:

- Pt able to sit 10 minutes before position changed required secondary to pain.

Palpation: Lumbosacral Region: Musculature, Posterior:

### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

- Extension
- Flexion (increased pain)
- Side Bending Left
- Side Bending Right

Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

- Extension
- Flexion

Left

Mild  
Mild  
Mild

Jan 20, 2014

50%  
75%  
75%  
75%

Right

Mild  
Mild  
Mild

Mar 04, 2014

100%  
100%  
100%  
100%  
100%  
100%

## Assessment

Pt appeared to be progressing well towards goals overall but has started to have high subjective c/o pain. He continues to be able to complete there-ex with correct technique.

## Plan

### Daily Plan:

- Continue w/ Current Rehabilitation Program.

Agree

03/19/2014 13:00

(FAX)

P.016/018

results PHYSIOTHERAPY Fax: 615-896-6825  
Patient: ARTHUR DAVIS  
Acct #: 124961

Mar 4 2014 11:52am

P003/003



Note Date: Mar 04, 2014

**Therapy  
Referral**

I have read the above report and request that my patient:

- ☒ Continue with treatment program as indicated above.  
☐ Continue treatment program for \_\_\_ days/week for \_\_\_ weeks.  
☐ Revise treatment program as indicated: \_\_\_\_\_  
☐ Progress to a home exercise program.  
☐ Be discharged.  
☐ Other: \_\_\_\_\_

Electronically authenticated.

Please sign  
and return

Lakota C. Hillis, PT(TN Lic: 8886), DPT  
Signed on Mar 04, 2014 13:19:11

Nicholas Cote DO

Date

3/7/14

Document ID: 0070090B.022  
Lakota C. Hillis, PT(TN Lic: 8886), DPT

Status: Signed off (secure electronic signature)

Page 2 of 2

03/19/2014 13:00

(FAX)



**Murfreesboro Medical Clinic**  
1272 Garrison Drive  
Murfreesboro, TN 37129  
615-867-8010 www.mmcclinic.com 1-800-842-6692

**Department of Internal and Family Medicine**

**Patient Name: ARTHUR C. DAVIS**  
Chart # 482122 Encounter Date: 03/06/2014

**Visit Summary**

<b>Patient Detail for ARTHUR C. DAVIS</b>		<b>MRN: 482122</b>	
<b>Contact</b>	ARTHUR DAVIS	<b>Date Of Birth</b>	REDACTED
<b>Address</b>	REDACTED MURFREESBORO, TN 371286537	<b>Gender</b>	Male
	REDACTED	<b>Marital Status</b>	D
		<b>Language</b>	English - preferred

- ◆ Health Maintenance
- ◆ Asthma
- ◆ Benign Essential Hypertension
- ◆ Esophageal Reflux

**Labs/Procedures/Imaging**

- ◆ LIPID; Done: 27Feb2014 08:04AM
- ◆ PSA; To Be Done: 06 Sep 2014
- ◆ CMP; To Be Done: 06 Sep 2014

Vital Signs			
Date	Description	Test	Result
06 Mar 2014 09:44 AM	recorded by: Vance, Christy	BP Systolic	124 mm[Hg]
		BP Diastolic	80 mm[Hg]
		Heart Rate	78 /min
		Body Mass Index Calculated	32.91

1 of 2

03/19/2014 13:00

(FAX)

P.018/018

Body Surface Area Calculated	2.32
Height	72 in
Weight	243 lb
O2 SAT	98 %

- ◆ Advair Diskus 250-50 MCG/DOSE Inhalation Aerosol Powder Breath Activated; ; Days: 90; Qty: 180; Refill: 0 (Active)
- ◆ CeleBREX 200 MG Oral Capsule; ; Days: 90; Qty: 90; Refill: 0 (Active)
- ◆ Lisinopril-Hydrochlorothiazide 20-25 MG Oral Tablet; ; Days: 90; Qty: 90; Refill: 0 (Active)
- ◆ AmlODIPine Besylate 10 MG Oral Tablet; ; Days: 0; Qty: ; Refill: 0 (Active)
- ◆ Omeprazole 20 MG Oral Tablet Delayed Release; ; Days: 0; Qty: ; Refill: 0 (Active)
- ◆ Flonase 50 MCG/ACT Nasal Suspension; ; Days: 0; Qty: ; Refill: 0 (Active)
- ◆ Spironolactone 25 MG Oral Tablet; ; Days: 0; Qty: ; Refill: 0 (Active)
- ◆ Bystolic 10 MG Oral Tablet; ; Days: 0; Qty: ; Refill: 0 (Active)
- ◆ Zyrtec Childrens Allergy 10 MG Oral Tablet Chewable; ; Days: 0; Qty: ; Refill: 0 (Active)
- ◆ Tramadol HCl 50 MG Oral Tablet; ; Days: 0; Qty: ; Refill: 0 (Active)
- ◆ ProAir HFA 108 (90 Base) MCG/ACT Inhalation Aerosol Solution; ; Days: 25; Qty: 8; Refill: 0 (Active)

- ◆ Intervertebral Disc Degeneration (Active)
- ◆ Lower Back Pain (Active)
- ◆ Somatic Dysfunction Of Rib Cage (Active)
- ◆ Somatic Dysfunction Of Pelvic Region (Active)
- ◆ Somatic Dysfunction Of Lumbar Region (Active)
- ◆ Somatic Dysfunction Of Thoracic Region (Active)
- ◆ Asthma (Active)
- ◆ Benign Essential Hypertension (Active)
- ◆ Esophageal Reflux (Active)

- ◆ OxyCODONE HCl CAPS; Reactions: Itching (Active)

- ◆ KATTINE,ALBERT 03/17/2014 2:45:00 PM
- ◆ LAB MMC,LAB 09/02/2014 1:10:00 PM
- ◆ COTE,NICHOLAS 09/08/2014 10:45:00 AM

Ambulatory Health Care Facilities      NICHOLAS COTE , D.O.  
 1272 Garrison Drive  
 Murfreesboro, TN 37129  
 (615)893-4480 (Work phone)

	SUMMARIZATION OF EPISODE NOTE	Encounter	March 6, 2014 09:30+0000
From	Enterprise EHR 11.203.4482.15631; Transform 3.2.0.23	Site	Murfreesboro Medical Clinic and SurgiCenter 1272 Garrison Drive Murfreesboro, TN 37129 (615)893-4480 (Work phone)
Created	March 6, 2014 10:25-0600	By	NICHOLAS COTE , D.O.



## Fax Message

---

**To:** scanning

**Fax:** 8666671987

**From:** Amor, Maribel

**Date:** 3/19/2014 12:13 PM

**Pages:** 1 of 10 (including this page)

**Subject:** paystubs

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If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.



Claim 9452367

*Maribel Amor, MST*  
*Senior Disability Benefit Manager*  
*Aetna Life Insurance Company*  
*Ph: 954-693-2140*  
*Fax: 860-907-4494*  
*E-mail: AmorM@Aetna.com*

# Highly Confidential Payroll Information      Chad Fiebig      3/19/2014 12:12 PM

Admin View Paychecks - Detail - Windows Internet Explorer - provided by Dell Client Engineering Team

Address: https://pwc.adp.com/jw/cfadmin/payroll/vp\_taskpage.asp?SelectedTask=AdminViewPaychecksDetailScreen&... Automatic Data Processing, Inc [US] Google

File Edit View Favorites Tools Help

Favorites Job Data Profile HR PS93 Inside Dell Home MY HR Tickets Kronos WORKFORCE CEN... Web Site Gallery Hours Correction

Kronos WORKFORCE CEN... Job Data My Worklist ADP ADP Admin View Paychecks...

View Stub Only

Employee: ARTHUR C. DAVIS ID: 00909800 Status: US-S TM-V Job: Exempt TM-Exempt ID: 02290224

Code: DMILP-DE Payroll: 1 Division: Department: Hire Date: 08/22/08 Retire Start: 12/31/12 Retire End: 12/31/12

Click here for a printable version of this page

Item	Rate Or Pay	Hours	Current Amount	YTD Amount
Salary Yr-Exempt	-24.00	1,795.02	38,579.90	
Overtime	10.4739	0.75	7.36	2,787.34
Vacation Pay	21.3456	24.00	512.17	2,556.18
Holiday Pay				1,694.82
PEA				1,812.41
Commission				12,283.04
S.P.F.			3,023.44	3,023.44
Group Term Life > \$50,000			0.37	24.80
Commission Premium-Q				1,028.42
Total Gross			4,739.52	63,394.15

Item	Current Amount	YTD Amount
Health Care Spending Account	-42.52	3,700.00
401(k) Savings Plan	284.51	3,802.17
Total	426.65	7,502.17

W2 Gross: 4,312.89 56,891.98

Item	Tax Current Amount	Tax YTD Amount
Federal Income Tax		3,101.10
Social Security (FICA)	183.08	2,567.15
Federal Medicare	66.66	865.57
Total	249.74	6,473.82

Item	Current Amount	YTD Amount
401(k) Loan 1	5.14	159.84
401(k) Loan 2	108.89	2,833.74
LTD	2.69	69.04
Supplemental Life Insurance	4.08	105.06
Group Term Life > \$50,000 Office	0.37	24.80

Internet | Protected Mode: On 10:25 AM 3/19/2014

# Highly Confidential Payroll Information      Chad Fiebig      3/19/2014 12:12 PM

Admin View Paychecks - Detail - Windows Internet Explorer provided by Dell Client Engineering Team

https://www.adp.com/tpwcf/admin/payroll/upi\_lastpage.asp?selected\_tabs=AdminViewPaychecksDetail&view=screen&... Automatic Data Processing, Inc [US] Google

File Edit View Favorites Tools Help

Favorites Job Data ProBl HR PS 9.1 Inside Del Home MY HR Tickets Kronos WORKFORCE CEN... Web Site Gal ery Hours Correction

Kronos WORKFORCE CEN... Job Data My Worklist ADP Admin View Paychecks...

View Stub Only

Employee	ID	Social Security	Status	Exemptions / Allowance	Number
ARTHUR C. DAV S	00000000	REDACTED	JS-S / TN-N	JS-7/8 TH-Exempt	01894306

Code	Paygroup	Division	Department	Act Date	Period Start	Period End	Pay Date
OMLP DEL				03/22/06	12/17/11	*2/20/12	01/05/12

Section	Hours On	Hours Off	Current Amount	Ytd Amount
Salary Non-Exempt			798.96	798.96
Overtime	2 7151	3 25	71.90	71.90
Holiday Pay	21 0255	40 00	641.81	841.81
PBA	21 0255	2 00	42.05	42.05
Group Term Life > 850,000			0.90	0.90
<b>Total Gross</b>			<b>1,754.82</b>	<b>1,754.82</b>

Section	Current Amount	Ytd Amount
Health Care Spending Account	142.31	142.31
401(k) Savings Plan	105.24	105.24
<b>Total</b>	<b>247.55</b>	<b>247.55</b>

W2 Gross 1,507.27 1,507.27

Section	Current Amount	Ytd Amount
Federal Income Tax	43.36	43.36
Social Security (FICA)	67.73	67.73
Federal Medicare	23.38	23.38
<b>Total</b>	<b>134.47</b>	<b>134.47</b>

Section	Current Amount	Ytd Amount
401(k) Loan 1	0.14	0.14
401(k) Loan 2	108.99	108.99
LTD	2.64	2.64
Supplemental Life Insurance	4.01	4.01
Group Term Life > 850,000 Other	0.90	0.90
Roth 401(k) Savings After Tax	87.70	87.70
<b>Total</b>	<b>210.38</b>	<b>210.38</b>

Net Pay 1,162.42

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Internet | Protected Mode On 10:52 AM 3/19/2014

# Highly Confidential Payroll Information      Chad Fiebig      3/19/2014 12:12 PM

Admin View Paychecks - Detail - Windows Internet Explorer provided by Dell Client Engineering Team

ADP https://pwc.adp.com/pwc/admin/payroll/vp\_cashpage.asp?selected\_task=AdminViewPaychecksDetail&emp\_screens= Automatic Data Processing, Inc. (US) Google

File Edit View Favorites Tools Help

Favorites Jos Data ProBI HR PS 9.1 Inside Dell Home MY HR Tickets Kronos WORKFORCE CEN... Web Slice Gallery Hours Correction

82 Kronos WORKFORCE CEN... Job Data My Worklist ADP ADP Admin View Paychecks...

View Status Only

ARTHUR C. DAVIS 00900888 REDACTED JS-S TN-N JS-S40 TN-Exempt 02315078

Code	Paygroup	Division	Department	Hire Date	Period Start	Period End	Pay Date
DML-P-DEL	1			05/22/05	12/15/12	12/20/12	01/04/13

Click here for a printable version of this page

Amount	Rate Of	Check	Hours	Current Amount	Ytd Amount	Check Detail	Amount
	%					Savings - REDACTED	*Payroll
Salary Non-Exempt		48.00		882.81	882.81	Checking	* 132.82
Holiday Pay	21.3400	48.00		1,024.34	1,024.34		
Group Term Life >				1.49	1.49		
\$50.00C							
Tota- Gross				1,798.74	1,798.74		

Current Amount	Ytd Amount
Health Care Spending Account	98.15
401(k) Savings Plan	192.44
Tota-	198.59

W2 Gross 1,510.15 1,510.15

Pay Current Amount	Tax Ytd Amount
Federal Income Tax	131.40
Social Security (FICA)	99.96
Federal Medicare	23.38
Tota-	254.76

Current Amount	Ytd Amount
401(k) Loan 1	0.14
401(k) Loan 2	198.99
LTD	2.17
Supplemental Life Insurance	4.08
Group Term Life >\$50,000 Off	1.49
Tota-	122.87

Net Pay 132.82

Internet Protected Mode On 10:51 AM 3/19/2014

# Highly Confidential Payroll Information      Chad Fiebig      3/19/2014 12:12 PM

Admin View Paychecks - Detail - Windows Internet Explorer provided by Dell Client Engineering Team

ADP <https://paw.adp.com/pawc/admin/payroll/vp/taskpage.asp?selectedTask=AdminViewPaychecksDetail&view=screens> Automatic Data Processing, Inc [US] Google

File Edit View Favorites Tools Help

Favorites Job Data ProB1 HR PS91 Inside Dell Home MY HR Tickets Kronos WORKFORCE CEN. Web Slice Gallery Hours Correction

Kronos WORKFORCE CEN. Job Data My Worklist ADP ADP Admin View Paychecks. X

Item	Tax Curr. Amount	Tax YTD Amount
Federal Income Tax		4,734.39
Social Security (FICA)	80.35	4,026.65
Federal Medicare	18.79	941.72
Total	99.14	9,702.77

Dell Marketing LP - One Dell Way Round Rock, TX 78682 - (512) 732-5111

ADP National Account Services  
Deductions for 401(k), 401(b), 403(b), 457(b), 529, and other

Employee	ID	Social Security	Status	Exemptions / Allowances	Prolog5_Small_Black_on_White_Transparent.gif (2963 bytes)
ARTHUR C. DAVIS	00900600	REDACTED	US-S TN-N	US-Exempt TN-Exempt	02

Code	Product	Division	Department	Start Date	Period Start	Period End	Pay Date
GMLPDEL				05/22/08	11/25/13	12/05/13	12/20/13

After-tax Deductions	Cumulative Amount	YTD Amount
401(k) Loan 1		34.93
401(b) Loan 2	102.99	2,833.74
LTD	2.77	50.42
Supplements: Life Insurance	4.08	106.08
Group Term Life>\$50,000 Other		31.29
Healthy Lifestyle Discount	-32.80	-422.50
Roth 401(k) Savings-After Tax		39.92
Total	82.74	2,679.88

Dell Marketing LP - One Dell Way Round Rock, TX 78682 - (512) 732-5111

ADP National Account Services  
Internet | Protected Mode: On

Done

Employee	ID	Social Security	Status	Exemptions / Allowances	Number
ARTHUR C. DAVIS	00900600	REDACTED	US-S TN-N	US-4/0 TN-Exempt	D2745545

# Highly Confidential Payroll Information      Chad Fiebig      3/19/2014 12:12 PM

Code	Paygroup	Division	Department	Hire Date	Period Start	Period End	Pay Date
DMLP-DEL	1			05/22/06	09/21/13	10/04/13	10/11/13
<b>Earnings</b>				<b>Net Pay</b>			
	Rate Of Pay	Check Hours	Current Amount	Ytd Amount	1,175.91		
Salary Non Exempt		-8.00	1,536.53	29,972.98			
Overtime	9.7557	3.75	36.58				
Overtime	10.2846	1.50	15.43	1,588.57			
Vacation Pay	21.3406	8.00	170.72	2,123.36			
Holiday Pay				1,707.22			
PBA				1,536.51			
Bereavement Pay				512.17			
Commissions				13,186.27			
Contests				25.00			
On the Spot Award				25.00			
SPIF				6,486.00			
Group Term Life > \$50,000			1.49	31.29			
Commission Premium-Q				688.01			
<b>Total Gross</b>			<b>1,760.75</b>	<b>57,882.38</b>			
<b>Pre-tax Deductions</b>				<b>Current Amount</b>	<b>Ytd Amount</b>		
Pretax Medical Plan				63.93	511.44		
Pretax Dental Plan				6.04	48.32		
Pretax Vision Plan				1.34	10.72		
Health Care Spending Account				96.15	2,019.15		
401(k) Savings Plan				87.96	3,215.95		
<b>Total</b>				<b>255.42</b>	<b>5,805.58</b>		
<b>W2 Gross</b>				<b>1,505.33</b>	<b>52,076.80</b>		
<b>Taxes</b>				<b>Tax Current Amount</b>	<b>Tax Ytd Amount</b>		
Federal Income Tax				105.72	3,907.15		
Social Security (FICA)				98.78	3,428.15		
Federal Medicare				23.10	801.74		
<b>Total</b>				<b>227.60</b>	<b>8,137.04</b>		
<b>After-tax Deductions</b>				<b>Current Amount</b>	<b>Ytd Amount</b>		
401(k) Loan 1					34.93		
401(k) Loan 2				108.99	2,288.79		
LTD				2.17	45.57		
Supplemental Life Insurance				4.08	85.68		
Group Term Life>\$50,000 Offse				1.49	31.29		
Healthy Lifestyle Discount				-32.50	-260.00		
Roth 401(k) Savings-After Tax				17.59	17.59		
<b>Total</b>				<b>101.82</b>	<b>2,243.85</b>		

Employee	Id	Social Security	Status	Exemptions / Allowances	Number		
ARTHUR C. DAVIS	00900600	REDACTED	US-S TN-N	US-4/0 TN-Exempt	D2725511		
Code	Paygroup	Division	Department	Hire Date	Period Start	Period End	Pay Date
DMLP-DEL	1			05/22/06	09/07/13	09/20/13	09/27/13
Earnings				Net Pay		1,944.92	
	Rate Of Pay	Check Hours	Current Amount	Ytd Amount	Direct Deposit Accounts		
Salary Non Exempt		-12.00	1,451.17	28,436.45	Amount		
Overtime	9.3292	5.75	53.64	1,536.56	Savings - X	REDACTED	100.00
Vacation Pay	21.3406	8.00	170.72	1,952.64	Checking - X	REDACTED	1,844.92

## Highly Confidential Payroll Information

Chad Fiebig

3/19/2014 12:12 PM

Holiday Pay			1,707.22
PBA	21.3406	4.00	1,536.51
Bereavement Pay			512.17
Commissions		1,188.98	13,186.27
Contests			25.00
On the Spot Award			25.00
SPIF			6,486.00
Group Term Life > \$50,000		1.49	29.80
Commission Premium-Q			688.01
Total Gross		2,951.36	56,121.63
Pretax Deductions		Current Amount	Ytd Amount
Pretax Medical Plan		63.93	447.51
Pretax Dental Plan		6.04	42.28
Pretax Vision Plan		1.34	9.38
Health Care Spending Account		96.15	1,923.00
401(k) Savings Plan		147.49	3,127.99
Total		314.95	5,550.16
W2 Gross		2,636.41	50,571.47
Taxes		Tax Current Amount	Tax Ytd Amount
Federal Income Tax		394.29	3,801.43
Social Security (FICA)		172.61	3,329.37
Federal Medicare		40.36	778.64
Total		607.26	7,909.44
After-tax Deductions		Current Amount	Ytd Amount
401(k) Loan 1			34.93
401(k) Loan 2		108.99	2,179.80
LTD		2.17	43.40
Supplemental Life Insurance		4.08	81.60
Group Term Life>\$50,000 Offse		1.49	29.80
Healthy Lifestyle Discount		-32.50	-227.50
Total		84.23	2,142.03

Memo Entries	Current	Year To Date
Salary NE Reg Hours - Memo	76.75	1,463.25

Employee	ID	Work Location	Status	Exemptions / Allowances	Number		
ARTHUR C. DAVIS	00900600	REDACTED	US-S TN-N	US-4/0 TN-Exempt	D2702364		
Code	Paygroup	Division	Department	Line Date	Period Start	Period End	Pay Date
DMLP-DEL	1			05/22/06	08/24/13	09/06/13	09/13/13
Earnings	Rate Of Pay	Check Hours	Current Amount	Ytd Amount	Net Pay		
Salary Non Exempt		-8.00	1,536.53	26,985.28		1,190.13	
Overtime	9.4847	5.00	47.42	1,482.92	Direct Deposit Accounts		Amount
Vacation Pay				1,781.92	Savings - REDACTED		100.00
Holiday Pay				1,707.22	Checking - REDACTED		1,090.13
PBA	21.3406	8.00	170.72	1,451.15	Memo Entries	Current	Year To Date
Bereavement Pay				512.17	Salary NE Reg Hours - Memo	79.25	1,386.50
Commissions				11,997.29			
Contests				25.00			
On the Spot Award				25.00			
SPIF				6,486.00			
Group Term Life > \$50,000			1.49	28.31			
Commission Premium-Q				549.53			
Total Gross			1,756.16	53,031.79			
Pretax Deductions			Current Amount	Ytd Amount			

# Highly Confidential Payroll Information      Chad Fiebig      3/19/2014 12:12 PM

Pretax Medical Plan	63.93	383.58
Pretax Dental Plan	6.04	36.24
Pretax Vision Plan	1.34	8.04
Health Care Spending Account	96.15	1,826.85
401(k) Savings Plan	87.73	2,973.58
Total	255.19	5,228.29
W2 Gross	1,500.97	47,803.50
<b>Taxes</b>		
Federal Income Tax	105.07	3,407.14
Social Security (FICA)	98.50	3,148.18
Federal Medicare	23.04	736.27
Total	226.61	7,291.59
<b>After-Tax Deductions</b>		
401(k) Loan 1		34.93
401(k) Loan 2	108.99	2,070.81
LTD	2.17	41.23
Supplemental Life Insurance	4.08	77.52
Group Term Life-\$50,000 Offse	1.49	28.31
Healthy Lifestyle Discount	-32.50	-195.00
Total	84.23	2,057.80

Employee	ID	Social Security	State	Exemptions / Allowances	Number		
ARTHUR C. DAVIS	00900600	REDACTED	US-S TN-N	US-4/0 TN-Exempt	D2677038		
Code	Paygroup	Division	Department	Emp Date	Period Start	Period End	Pay Date
DMLP-DEL	1			05/22/06	08/10/13	08/23/13	08/30/13
Earnings	Rate Of Pay	Check Hours	Current Amount	Ytd Amount	Net Pay		
Salary Non Exempt		-12.00	1,451.16	25,448.75	Direct Deposit Accounts		Amount
Overtime	8.5363	10.00	85.36		Savings - REDACTED		100.00
Overtime	9.9839	2.75	27.46	1,435.50	Checking - REDACTED		1,137.95
Vacation Pay				1,781.92	Memo Entries	Current	Year To Date
Holiday Pay				1,536.50	Salary NE Reg Hours - Memo	80.00	1,307.25
PBA	21.3406	12.00	256.09	1,451.15			
Bereavement Pay				512.17			
Commissions				10,563.02			
Contests				25.00			
On the Spot Award				25.00			
SPIF				6,486.00			
Group Term Life > \$50,000			1.49	26.82			
Commission Premium-Q				549.53			
Total Gross			1,821.56	49,841.36			
Pretax Deductions			Current Amount	Ytd Amount			
Pretax Medical Plan			63.93	319.65			
Pretax Dental Plan			6.04	30.20			
Pretax Vision Plan			1.34	6.70			
Health Care Spending Account			96.15	1,730.70			
401(k) Savings Plan			91.00	2,814.14			
Total			258.46	4,901.39			
W2 Gross			1,563.10	44,939.97			
Taxes			Tax Current Amount	Tax Ytd Amount			
Federal Income Tax			114.39	2,961.43			
Social Security (FICA)			102.55	2,960.75			



## Highly Confidential Payroll Information

Chad Fiebig

3/19/2014 12:12 PM

Federal Medicare	23.98	692.43
Total	240.92	6,614.61
After tax Deductions	Current Amount	Ytd Amount
401(k) Loan 1		34.93
401(k) Loan 2	108.99	1,961.82
LTD	2.17	39.06
Supplemental Life Insurance	4.08	73.44
Group Term Life>\$50,000 Offse	1.49	26.82
Healthy Lifestyle Discount	-32.50	-162.50
Total	84.23	1,973.57

AETNA -&gt; 18666671987

3/19/2014 12:13 PM



## Fax Message

---

**To:** Scanning  
**Fax:** 8666671987  
**From:** Amor, Maribel  
**Date:** 3/19/2014 12:10 PM  
**Pages:** 1 of 3 (including this page)  
**Subject:** payroll information

---

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*Maribel Amor, MST  
Senior Disability Benefit Manager  
Aetna Life Insurance Company  
Ph: 954-693-2140  
Fax: 860-907-4494  
E-mail: AmorM@Aetna.com*

**Amor, Maribel**

---

**From:** Chad\_Fiebig@Dell.com  
**Sent:** Wednesday, March 19, 2014 12:06 PM  
**To:** Amor, Maribel  
**Subject:** RE: Payroll needed  
**Attachments:** davis.docx

Dell - Internal Use - Confidential

Rate Code	Seq	Comp Rate	Currency	Frequency
1 BASEA	0	44,388.490000	USD	A
2 STIA	1	19,023.640000	USD	A

**From:** Amor, Maribel [mailto:AmorM@aetna.com]  
**Sent:** Tuesday, March 18, 2014 3:07 PM  
**To:** Fiebig, Chad  
**Subject:** Payroll needed

Arthur Davis  
 Claim 9452367  
 ID 900600  
 Dell Inc

Chad,

Please provide me with the following:

1. 1<sup>st</sup> and last paystub for 2012
2. 1<sup>st</sup> pay stub for 2013
3. The last four (4) paystubs as of 10/08/2013
4. The base salary as of 10/08/2013, and the commissions as of 10/08/2013
- 5.

Thank you! Maribel

Maribel Amor, MST  
 Senior Disability Benefit Manager  
 Aetna Life Insurance Company  
 Ph: 954-693-2140  
 Fax: 860-907-4494  
 E-mail: AmorM@Aetna.com

This e-mail may contain confidential or privileged information. If you think you have received this e-mail in error, please advise the sender by reply e-mail and then delete this e-mail immediately. Thank you. Aetna



## Facsimile Transmittal Sheet

To:	From:
Dr. Murfreesboro Results Physiotherapy	Aetna Disability
Employer:	Date:
Dell Inc	03/18/2014
Fax Number: 615-896-6825	CLAIM NUMBER:
	9452367
Phone number:	Sender's Phone Number:
	800-354-1779
	Sender's FAX Number:
	1-866-667-1987
Re: MR. ARTHUR DAVIS	Total No. of Pages Including Cover:
Date of Birth: REDACTED	

Urgent For Review Please Comment xx Please Reply Please Recycle

Please send me the progress notes and evaluations for March 2014. Mr. Davis is being evaluated to receive LTD benefits. Thanks, Maribel

Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

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## NOTICE TO RECIPIENT(S) OF INFORMATION:

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

The information contained in this document is CONFIDENTIAL. If you have received this in error, please fax immediately to 1-866-667-1987. Thank you.

Enclosed:



Results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Mar 19 2014 10:16am

P002

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Visit Date: Mar 06, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 19  
Cxl/Ns: 1

Employer: DELL  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

Pt with continued high subjective c/o pain. Kept repeating how things have all gone "down hill" after forgetting to take his Tylenol the other day.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:

- Score 48

## Objective Examination

### Observations:

- Pt able to sit 15 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:** Left Right

### Guarding:

- |                      |      |      |
|----------------------|------|------|
| • Gluteus Maximus    | Mild | Mild |
| • Piriformis         | Mild | Mild |
| • Quadratus Lumborum | Mild | Mild |

### Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

- |                           |      |
|---------------------------|------|
| • Extension               | 100% |
| • Flexion(increased pain) | 100% |
| • Side Bending Left       | 100% |
| • Side Bending Right      | 100% |

### Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

- |             |      |
|-------------|------|
| • Extension | 100% |
| • Flexion   | 100% |

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Manual Therapy Techniques	97140	1	10
• Therapeutic Activities	97530	2	25
• Therapeutic Procedure	97110	2	20

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1 Time Elapsed: 20 Minutes, Description: see exercise log, Charge As: Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1 Time Elapsed: 25 Minutes, Description: see exercise log, Charge As: Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

- Lumbosacral Spine(This visit) Did Not Perform: This visit

Document ID: 0070090B.023  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2



- Vertebral Jt Seg Mobilization 1

Time Elapsed: 4 Minutes, Grade: 4, Body Position: supine,  
Additional Detail: bilat, Pressure: Oscillatory, Technique 1: light  
long axis lumbar distraction, Charge As: Manual Therapy  
Techniques, Billing Code: 97140.

Did Not Perform: This visit

- Vertebral Jt Seg Mobilization 2(This visit)

**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM

Time Elapsed: 6 Minutes, Tx Depth: Superficial, Technique:  
Strumming, Charge As: Manual Therapy Techniques, Billing Code:  
97140.

Did Not Perform: This visit

**Manual Interventions: Taping To Stabilize/Align:**

- Strapping Activity 1(This visit)

**Modalities:**

- Electric Stim, Unattended(This visit)

Did Not Perform: This visit

**Timed Code Total Time:**

- 55 Minutes

## Assessment

Pt functionally able to perform all there-ex with correct technique. Continues to have high subjective c/o pain. Pt returning to MD today for follow up.

## Plan

**Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Mar 06, 2014 09:28:34



Results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
PSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Mar 19 2014 10:17am

P004

Visit Date: Mar 10, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 20  
Cxl/Ns: 2

Employer: DELL  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 48

## Objective Examination

### Observations:

- Pt able to sit 15 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:** Left Right

### Guarding:

- |                      |      |      |
|----------------------|------|------|
| • Gluteus Maximus    | Mild | Mild |
| • Piriformis         | Mild | Mild |
| • Quadratus Lumborum | Mild | Mild |

### Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

- |                           |      |
|---------------------------|------|
| • Extension               | 100% |
| • Flexion(increased pain) | 100% |
| • Side Bending Left       | 100% |
| • Side Bending Right      | 100% |

### Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

- |             |      |
|-------------|------|
| • Extension | 100% |
| • Flexion   | 100% |

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Therapeutic Activities	97530	2	25
• Therapeutic Procedure	97110	2	20

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1
- Time Elapsed: 20 Minutes, Description: see exercise log, Charge As: Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1
- Time Elapsed: 25 Minutes, Description: see exercise log, Charge As: Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

- Lumbosacral Spine(This visit)
  - Vertebral Jt Seg Mobilization 1(This visit)
  - Vertebral Jt Seg Mobilization 2(This visit)
- Did Not Perform: This visit  
Did Not Perform: This visit  
Did Not Perform: This visit

### Manual Interventions: Lower Quarter Soft Tissue:

- Thoracolumbar PVM(This visit)
- Did Not Perform: This visit

Document ID: 0070090B.025  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2





Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Mar 10, 2014

**Manual Interventions: Taping To Stabilize/Align:**

- Strapping Activity 1(This visit)

Did Not Perform: This visit

**Modalities:**

- Electric Stim, Unattended(This visit)

Did Not Perform: This visit

**Timed Code Total Time:**

- 45 Minutes

**Assessment**

Pt able to complete all high level functional there-ex with no movement substitutions. Pt with continued high subjective c/o pain.

**Plan**

**Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Mar 10, 2014 12:21:10



results PHYSIOTHERAPY  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Mar 19 2014 10:17am

P006

Note Date: Mar 04, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 18  
Cxl/Ns: 1

Employer: DELTA  
Insured:

## Progress Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

### Subjective Examination

**Chief Complaint:**

- Pain: Current Severity: 0/10.

**Client Knowledge/Awareness of:**

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 48

### Objective Examination

**Observations:**

- Pt able to sit 10 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:**

**Guarding:**

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

**Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:**

- Extension
- Flexion(increased pain)
- Side Bending Left
- Side Bending Right

**Range of Motion: Spine: Post-Treatment: Active Lumbosacral:**

- Extension
- Flexion

**Left**

Mild  
Mild  
Mild

**Jan 20, 2014**

50%  
75%  
75%  
75%

**Right**

Mild  
Mild  
Mild

**Mar 04, 2014**

100%  
100%  
100%  
100%

**Mar 04, 2014**

100%  
100%

### Assessment

Pt appeared to be progressing well towards goals overall but has started to have high subjective c/o pain. He continues to be able to complete there-ex with correct technique.

### Plan

**Daily Plan:**

- Continue w/ Current Rehabilitation Program.



Patient: ARTHUR DAVIS  
Acct #: 124961

Note Date: Mar 04, 2014

**Therapy  
Referral**

I have read the above report and request that my patient:

- ☐ Continue with treatment program as indicated above.  
☐ Continue treatment program for \_\_\_ days/week for \_\_\_ weeks.  
☐ Revise treatment program as indicated: \_\_\_\_\_  
☐ Progress to a home exercise program.  
☐ Be discharged.  
☐ Other: \_\_\_\_\_

Electronically authenticated.

**Please sign  
and return**

Lakota C. Hillis, PT(TN Lic: 8886), DPT  
Signed on Mar 04, 2014 13:19:11

\_\_\_\_\_  
**Nicholas Cote DO**\_\_\_\_\_  
**Date**



results PHYSIOTHERAPY  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
PSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Mar 19 2014 10:18am

P008

Visit Date: Mar 04, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 18  
Cxl/Ns: 1

Employer: DELL  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 0/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 48

## Objective Examination

### Observations:

- Pt able to sit 10 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:** Left Right

### Guarding:

- |                      |      |      |
|----------------------|------|------|
| • Gluteus Maximus    | Mild | Mild |
| • Piriformis         | Mild | Mild |
| • Quadratus Lumborum | Mild | Mild |

### Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

- |                           |      |
|---------------------------|------|
| • Extension               | 100% |
| • Flexion(increased pain) | 100% |
| • Side Bending Left       | 100% |
| • Side Bending Right      | 100% |

### Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

- |             |      |
|-------------|------|
| • Extension | 100% |
| • Flexion   | 100% |

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Electrical Stimulation (unattended)	97014	1	n/a
• Manual Therapy Techniques	97140	1	10
• Therapeutic Activities	97530	2	25
• Therapeutic Procedure	97110	2	20

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1

Time Elapsed: 20 Minutes, Description: see exercise log, Charge As: Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1

Time Elapsed: 25 Minutes, Description: see exercise log, Charge As: Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

- Lumbosacral Spine(This visit)

Did Not Perform: This visit

Document ID: 0070090B.021  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2

Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Mar 04, 2014

- Vertebral Jt Seg Mobilization 1

Time Elapsed: 10 Minutes, Grade: 4, Body Position: supine,  
Additional Detail: bilat, Pressure: Oscillatory, Technique 1: light  
long axis lumbar distraction, Charge As: Manual Therapy  
Techniques, Billing Code: 97140.

Did Not Perform: This visit

- Vertebral Jt Seg Mobilization 2(This visit)

**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

Did Not Perform: This visit

**Manual Interventions: Taping To Stabilize/Align:**

- Strapping Activity 1(This visit)

Did Not Perform: This visit

**Modalities:**

- Electric Stim, Unattended

Time Elapsed: 12 Minutes, Location: lumbar, Performed With:  
moist heat, Mode: Continuous, Type: Interferential, Clinical Use:  
Post Activity, Charge As: E-Stim, Unattended, Billing Code: 97014.

**Timed Code Total Time:**

- 55 Minutes

## Assessment

Pt able to complete there-ex with correct technique but with continued high subjective c/o pain.

## Plan

**Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Mar 04, 2014 13:17:42



Results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

**Patient:** ARTHUR DAVIS  
**Acct #:** 124961  
**DOB:** REDACTED  
**Physician:** Nicholas Cote DO  
**Phys Fax:** (615) 867-7945  
**Physician:** Not Specified  
**Clinician:** Lakota C. Hillis  
**FSC:** Commercial Insurance  
**Case Mgr:**  
**Payor:** AETNA  
**Pol/Claim#:**

Mar 19 2014 10:18am

P010

**Visit Date:** Mar 11, 2014  
**Phys Phone:** (615) 867-8010  
**SSN:** XXX-XX-XXXX  
**Inj. Date:** Jan 20, 2014  
**Surg. Date:**  
**Visits:** 21  
**Cxl/Ns:** 2  
**Employer:** DELL  
**Insured:**

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 48

## Objective Examination

### Observations:

- Pt able to sit 15 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:** Left Right

### Guarding:

- |                      |      |      |
|----------------------|------|------|
| • Gluteus Maximus    | Mild | Mild |
| • Piriformis         | Mild | Mild |
| • Quadratus Lumborum | Mild | Mild |

### Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

- |                           |      |
|---------------------------|------|
| • Extension               | 100% |
| • Flexion(increased pain) | 100% |
| • Side Bending Left       | 100% |
| • Side Bending Right      | 100% |

### Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

- |             |      |
|-------------|------|
| • Extension | 100% |
| • Flexion   | 100% |

## Treatments

### Documented Procedural Code Summary:

- | Description              | Code  | Units | Minutes |
|--------------------------|-------|-------|---------|
| • Therapeutic Activities | 97530 | 2     | 25      |
| • Therapeutic Procedure  | 97110 | 2     | 20      |

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1
- Time Elapsed: 20 Minutes, Description: see exercise log, Charge As: Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1
- Time Elapsed: 25 Minutes, Description: see exercise log, Charge As: Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

- Lumbosacral Spine(This visit)
  - Vertebral Jt Seg Mobilization 1(This visit)
  - Vertebral Jt Seg Mobilization 2(This visit)
- Did Not Perform: This visit  
Did Not Perform: This visit  
Did Not Perform: This visit

### Manual Interventions: Lower Quarter Soft Tissue:

- Thoracolumbar PVM(This visit)
- Did Not Perform: This visit

Document ID: 00700908.026  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2



results PHYSIOTHERAPY Fax: 615-896-6825  
Patient: ARTHUR DAVIS  
Acct #: 124961

Mar 19 2014 10:19am

P011

Visit Date: Mar 11, 2014

---

**Manual Interventions: Taping To Stabilize/Align:**

- Strapping Activity 1(This visit)

Did Not Perform: This visit

**Modalities:**

- Electric Stim, Unattended(This visit)

Did Not Perform: This visit

**Timed Code Total Time:**

- 45 Minutes

**Assessment**

Pt functionally able to perform all there-ex with no compensation strategies. Pt requested to increase reps and resistance on there-ex. Continued high subjective C/O pain.

**Plan**

**Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

---

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Mar 11, 2014 12:47:03



Results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Mar 19 2014 10:19am

P012

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Visit Date: Mar 13, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 22  
Cxl/Ns: 2

Employer: DELL  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

### Subjective Examination

Pt states he is having a lot of pain still.

#### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 48

### Objective Examination

#### Observations:

- Pt able to sit 15 minutes before position changed required secondary to pain. Gross Movements: Subjective c/o pain higher than objective findings. Pt able to complete all there-ex and there-act with correct technique/no compensations but required 2 attempts for supine to sit transitions with therapist standing next to plinth.

#### Palpation: Lumbosacral Region: Musculature, Posterior:

##### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

#### Left

Mild  
Mild  
Mild

#### Right

Mild  
Mild  
Mild

#### Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

- Extension 100%
- Flexion(increased pain) 100%
- Side Bending Left 100%
- Side Bending Right 100%

#### Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

- Extension 100%
- Flexion 100%

### Treatments

#### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Therapeutic Activities	97530	2	25
• Therapeutic Procedure	97110	2	20

#### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1

Time Elapsed: 20 Minutes, Description: see exercise log, Charge As: Therapeutic Exercise, Billing Code: 97110.

#### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1

Time Elapsed: 25 Minutes, Description: see exercise log, Charge As: Therapeutic Activities, Billing Code: 97530.

#### Manual Interventions: Vertebral Joint Segments:

- Lumbosacral Spine(This visit)
- Vertebral Jt Seg Mobilization 1(This visit)

Did Not Perform: This visit  
Did Not Perform: This visit

Document ID: 0070090B.027  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2





---

• Vertebral Jt Seg Mobilization 2(This visit)	Did Not Perform: This visit
<b>Manual Interventions: Lower Quarter Soft Tissue:</b>	
• Thoracolumbar PVM(This visit)	Did Not Perform: This visit
<b>Manual Interventions: Taping To Stabilize/Align:</b>	
• Strapping Activity I(This visit)	Did Not Perform: This visit
<b>Modalities:</b>	
• Electric Stim, Unattended(This visit)	Did Not Perform: This visit
<b>Timed Code Total Time:</b>	
• 45 Minutes	

## Assessment

Pt able to demonstrate correct technique. High subjective c/o pain.  
**Treatment Emphasis to focus on: Maximizing function related to:**  
• ADL's. Work performance.

## Plan

### Daily Plan:

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

---

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Mar 13, 2014 13:37:01



Results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Mar 19 2014 10:19am

P014

Visit Date: Mar 17, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 23  
Cxl/Ns: 2  
Employer: DELL  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

Pt reports "burning sensation" on bottoms of his feet with continued c/o pain in his low back.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:

- Score 48

## Objective Examination

### Observations:

- Pt able to sit 15 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:** Left Right

### Guarding:

- |                      |      |      |
|----------------------|------|------|
| • Gluteus Maximus    | Mild | Mild |
| • Piriformis         | Mild | Mild |
| • Quadratus Lumborum | Mild | Mild |

### Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

- |                           |      |
|---------------------------|------|
| • Extension               | 100% |
| • Flexion(increased pain) | 100% |
| • Side Bending Left       | 100% |
| • Side Bending Right      | 100% |

### Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

- |             |      |
|-------------|------|
| • Extension | 100% |
| • Flexion   | 100% |

### Reflex/Sensory Integrity:

- Dermatomal Sensation: Intact and Equal Bilaterally. (Lower Extremity). Neurology intact to strength and sensation testing in bilat LE.

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Therapeutic Activities	97530	2	25
• Therapeutic Procedure	97110	2	20

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1
- Time Elapsed: 20 Minutes, Description: see exercise log, Charge As: Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1
- Time Elapsed: 25 Minutes, Description: see exercise log, Charge As: Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

- Lumbosacral Spine(This visit) Did Not Perform: This visit
- Vertebral Jt Seg Mobilization 1(This visit) Did Not Perform: This visit

Document ID: 0070090B.028  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2

Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Mar 17, 2014

- Vertebral Jt Seg Mobilization 2(This visit)

Did Not Perform: This visit

**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

Did Not Perform: This visit

**Manual Interventions: Taping To Stabilize/Align:**

- Strapping Activity 1(This visit)

Did Not Perform: This visit

**Modalities:**

- Electric Stim, Unattended(This visit)

Did Not Perform: This visit

**Timed Code Total Time:**

- 45 Minutes

## Assessment

Pt with continued high subjective c/o pain but is able to perform all there-ex with correct technique and no substitutions.

## Plan

**Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Mar 17, 2014 12:09:51



## Fax Message

---

**To:** Scanning  
**Fax:** 8666671987  
**From:** Amor, Maribel  
**Date:** 3/18/2014 4:19 PM  
**Pages:** 1 of 3 (including this page)  
**Subject:** Praxis Referral

---

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Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Claim number 9452367

*Maribel Amor, MST  
Senior Disability Benefit Manager  
Aetna Life Insurance Company  
Ph: 954-693-2140  
Fax: 860-907-4494  
E-mail: AmorM@Aetna.com*

## PRAXIS REFERRAL

Date: 03/18/2014

Requested by: Maribel Amor

Claimant Name: Arthur Davis

SSN: REDACTED

System: WKAB

WKAB Claim Number: 9452367

Policy Holder Name: Dell Inc

Claimants Address: REDACTED Murfreesboro, TN 37128

Date Of Birth: REDACTED

Date of Disability: 10/09/2013

Date of Injury: 09/17/2013, MVA

LTD Benefit Start Date: 04/07/2014

LTD Minimum Benefit: 100 or 10% of the GMB

STD Benefit Start Date (check cutting only): N/A

Gross LTD Benefit Less Other Income Offsets = Net LTD Benefit: \$3,170.61 GMB, net benefit \$3,170.61 no other income identified.

Description of Third Party Settlement Information: MVA

Carrier Information: (Name, Claim Number, Adjuster's information and phone number): unknown

**David Clarke of Murfreesboro TN is representing claimant for the back injury.**

(615) 796-6299

111 North Maple Street, Murfreesboro, TN 37130



## Fax Message

---

**To:** SCANNING

**Fax:** 8666671987

**From:** Amor, Maribel

**Date:** 3/13/2014 12:28 PM

**Pages:** 1 of 7 (including this page)

**Subject:** NOTE FROM DR. GREEN/PAIN MGT.

---

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Claim 9452367

Thanks, Maribel

*Maribel Amor, MST  
Senior Disability Benefit Manager  
Aetna Life Insurance Company  
Ph: 954-693-2140  
Fax: 860-907-4494  
E-mail: AmorM@Aetna.com*



03/11/2014 09:48

(FAX)

P.001/005

3/7/2014 4:51 PM

AETNA -&gt; 16158677974

Page 1 of 5



## Fax Message

To: Dr. Green

Fax: 615-867-7974

From: Amor, Maribel

Date: 3/7/2014 4:51 PM

Pages: 1 of 5 (including this page)

Subject: Request for medical evidence.

\* Patient has not an  
evaluation with Dr. Green.  
1st Appt is 4.2.14  
Thank You

**Disclaimer:**

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3/13/2014 12:28 PM

AETNA -> 18666671987

Page 4 of 7

03/11/2014 09:48

(FAX)

P.002/005

3/7/2014 4:51 PM

AETNA -> 16158677974

Page 2 of 5

*Maribel Amor, MST*  
*Senior Disability Benefit Manager*  
*Aetna Life Insurance Company*  
*Ph: 954-693-2140*  
*Fax: 860-907-4494*  
*E-mail: AmorM@Aetna.com*

03/11/2014 09:48

(FAX)

P.003/005

3/7/2014 4:51 PM

AETNA -&gt; 16158677974

Page 3 of 5



## Facsimile Transmittal Sheet

To:	From:
Dr. Brenna Green	Aetna Disability
Employer:	Date:
Dell Inc	03/07/2014
Fax Number: 615-867-7974	CLAIM NUMBER:
	9452367
Phone number:	Sender's Phone Number:
	800-354-1779
	Sender's FAX Number:
	1-866-667-1987
Re: MR. ARTHUR DAVIS	Total No. of Pages Including Cover:
Date of Birth: REDACTED	

Urgent For Review Please Comment xxPlease Reply Please Recycle

Dear Dr. Green:

Please complete the attached form and submit to Aetna the initial evaluation. We are reviewing Mr. Davis for eligibility to receive LTD benefits. Thanks, Maribel

Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

## Disclaimer:

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Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

The information contained in this document is CONFIDENTIAL. If you have received this in error, please fax immediately to 1-866-667-1987. Thank you.

Enclosed:

Attending Physician Statement

03/11/2014 09:48

(FAX)

P.004/005

3/7/2014 4:51 PM

AETNA -&gt; 16158677974

Page 4 of 5

Claim Number: 9452367

**aetna**

Attending Physician Statement –  
Musculoskeletal: Orthopaedic Surgery,  
Spinal Surgery, Physiatry, Podiatry, Chiro

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: 800-354-1779  
Fax: 1-866-667-1987

## 1. Patient Information

Name			Employer Name			Job Title	
Year of Birth	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No	Height (ft/in.)	Weight (lbs.)	BMI	Blood Pressure	Date Measured

## 2. Physician Information

Name			Specialty	
Tax I.D. Number		Telephone Number (include area code)		Fax Number (include area code)

## 3. Management Information

Disability Benefits Manager MARIBEL AMOR	Telephone Number (include area code) 800-354-1779	Fax Number (include area code) 1-866-667-1987
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## 4. Treatment Information

First Day recommended out of Work	Initial Treatment Date	Last Appointment Date	Surgery Date
Medication (Name, Dosage and Frequency)			
Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Hospitalization Admitted on / / Discharged on / /		Recent Surgery Date (MM/DD/YYYY) / /

## 5. Clinical Condition

Diagnosis	ICD9 Code(s)	Procedure (if applicable)	CPT Code(s)
Is this condition responsible for any functional impairment?		<input type="checkbox"/> Yes, complete Sections 6, 7, 8 and 9 <input type="checkbox"/> No, provide a release to full duty in Section 9	
Is the condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Date of Injury / Illness / /	

## 6. Treatment Plan

Facility Name	Telephone Number (include area code)
Address (Include Zip Code)	

## 7. Objective Data that documents a functional impairment

Please record vital signs and describe physical exam (Quantitative ROM, Gait, Motor/Sensory/DTR, Neuro Findings, Effusions, Girth of Extremities) or WNL
Diagnostic Tests (X-Rays, CT / MRI, Myelogram, Discogram, Arthrogram, EMG/NCV, Bone Scans, Lab Test, etc.) or WNL
Other (PT/OT status, Pre & Post Surgical Indications and/or complications) or WNL

## 8. Work Restrictions

--

## 9. Return to Work Status

<input type="checkbox"/> Able to return to full duty on (date): / /
<input type="checkbox"/> Able to work with restrictions. Can return to work on (date): / / Work restrictions will apply until (date): / /
<input type="checkbox"/> I am unable to release this patient. I anticipate significant clinical improvement by date: / / Next appointment (date): / /

## 10. Signature

Physician's Signature	Date (MM/DD/YYYY) / /
Physician Name: _____	Specialty: _____
Phone Number: _____	Fax Number: _____
Address: _____	

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.

WKAB- GR-68332 (7-13)



03/11/2014 09:49

(FAX)

P.005/005

3/7/2014 4:51 PM

AETNA -&gt; 16158677974

Page 5 of 5

Claim Number: 9452367

Patient Name	Year of Birth
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**11. Misrepresentation**

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

WKAB  
GR-68332 (7-13)

Page 2





687103

**aetna**<sup>SM</sup>

846-6607-1987

## Fax Message

---

**To:** Dr. Renfro  
**Fax:** 6158344722  
**From:** Turner, Akinkawon  
**Date:** 3/5/2014 10:33 AM  
**Pages:** 1 of 8 (including this page)  
**Subject:** Arthur Davis REDACTED

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**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

## Progress Note

<b>Patient Name:</b>	Arthur Davis, Jr.	<b>Visit Date:</b>	March 11, 2014
<b>Patient ID:</b>	687103	<b>Provider:</b>	R.J. Renfro, MD
<b>Sex:</b>	Male	<b>Location:</b>	Harding Place
<b>Birthdate:</b>	<b>REDACTED</b>	<b>Location Address:</b>	394 Harding Place Suite 200 Nashville, TN 372113980
<b>Primary Care Provider:</b>	Tadayuki Yoneyama MD	<b>Location Phone:</b>	(615) 834-4482
<b>Referring Provider:</b>	Former Patient		

### Chief Complaint

- right shoulder
- left knee

### History Of Present Illness

Arthur C. Davis Jr. is a 50 year old Black/African American male who presents today for

Followup of his right shoulder rotator cuff repair that is 6 weeks postop and his left knee meniscal tears. He wants to schedule his left knee surgery in approximately 4 weeks. We discussed that surgery. He is in therapy with the shoulder needs to continue that and now can and a light strengthening program. He will followup in 4 weeks.

### Past Medical History

Disease Name	Date Onset	Notes
Asthma	--	--
Degeneration of lumbar intervertebral disc	11/07/2013	--
High blood pressure	--	--
Rotator Cuff Sprain/Tear	10/07/2013	--
Rotator Cuff Tear, Non-Trauma	10/07/2013	--
Sciatica	11/02/2013	--
Sprain/Strain	10/18/2013	--
Sprain/Strain, Lumbar	10/18/2013	--
Tear, Medial Meniscus	01/28/2014	--

### Past Surgical History

Procedure Name	Date	Notes
Hernia	--	--
Joint surgery (arthroscopic or open)	2004	left knee
Sinus Surgery	--	--

### Medication List

Name	Date Started	Instructions
Advair Diskus Inhalation disk with device 250-50 mcg/dose	07/19/2013	--
amlodipine Oral tablet 10 mg	09/10/2013	--
Celebrex Oral capsule 200 mg	07/12/2013	--
ciprofloxacin Oral tablet 500 mg	07/11/2013	--
clotrimazole-betamethasone Topical cream 1-0.05 %	08/13/2013	--
fluticasone Nasal spray,suspension 50 mcg/actuation	07/19/2013	--
lisinopril-hydrochlorothiazide Oral tablet 20-25 mg	09/23/2013	--
methylprednisolone Oral tablets,dose pack 4 mg	09/19/2013	--
metoprolol succinate Oral tablet extended release 24 hr 50 mg	07/31/2013	--

[Digital Signature Validated]

naproxen Oral tablet 500 mg	09/27/2013	--
Neurontin oral capsule 300 mg	12/19/2013	1 capsule (300 mg) by oral route every eight hours for 30 days
omeprazole Oral capsule, delayed release (DR/EC) 20 mg	07/19/2013	--
potassium chloride Oral tablet extended release 10 mEq	08/06/2013	--
prednisone Oral tablet 20 mg	09/27/2013	--
spironolactone Oral tablet 25 mg	08/13/2013	--
Ultram Oral tablet 50 mg	02/26/2014	take 1 tablet (50 mg) by oral route every 6 hours as needed for 15 days

**Allergy List**

Allergen Name	Date	Reaction	Notes
codeline sulfate	--	itching/rash	--

**Family Medical History**

Disease Name	Relative/Age	Notes
Family history of arthritis	/	--
Family history of heart disease	Mother/ /	--

**Social History**

Finding	Status	Start/Stop	Quantity	Notes
Alcohol Intake	Never	-/--	--	--
Tobacco	Never	-/--	--	--

**Review of Systems****Constitutional**

- o Denies : fatigue, weight loss, weight gain

**Gastrointestinal**

- o Denies : heartburn, hematemesis

**Genitourinary**

- o Denies : dysuria

**Neurologic**

- o Denies : muscular weakness, incoordination, tingling or numbness, loss of balance

**Musculoskeletal**

- o Admits : joint pain, night pain

**Psychiatric**

- o Denies : depression

**Vitals**

Date	Time	BP	Position	Site	L/R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m <sup>2</sup>	BSA m <sup>2</sup>	O2 Sat	HC
12/19/2013	03:05 PM							18		236lbs 0oz	6' 0"	32.01	2.33		

**Assessment**

[Digital Signature Validated]



- Rotator Cuff Sprain/Tear 840.4
- Rotator Cuff Tear, Non-Trauma 727.61
- Tear, Medial Meniscus 836.0

**Plan**

**Instructions**

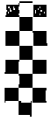
- This note was generated using EMR and voice recognition software and therefore may contain unedited errors.

**Disposition**

- Continue PT
- RTC in 4 weeks

**Electronically Signed by:** R.J. Renfro, MD -Author on March 11, 2014 03:51:43 PM

[Digital Signature Validated]



687103

**aetna**<sup>SM</sup>

866-6607-1987

## Fax Message

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**To:** Dr. Renfro  
**Fax:** 6158344722  
**From:** Turner, Akinkawon  
**Date:** 3/5/2014 10:33 AM  
**Pages:** 1 of 8 (including this page)  
**Subject:** Arthur Davis **REDACTED**

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Claim Number: 9452367



# Capabilities and Limitations Worksheet

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: 800-354-1779  
Fax: 1-866-667-1987

Employee Name (Last, First, Middle Initial) <b>DAVIS, ARTHUR</b>		Social Security Number <b>REDACTED</b>		Year of Birth <b>REDACTED</b>	
Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		Job Title <b>Inside Sales Manager</b>		Control Number	
Current Diagnosis <b>Bilateral rotator cuff repairs</b>		Medications: <b>Oxycodone</b>			

Indicate the percent of the day the following activities can be performed:  
☒ Occasional 1-33% or .5-2.5 hrs. ☐ Frequent 34-66% or 2.6-5.0 hrs. ☐ Continuous 67-100% or 5.1-8 hrs. or ☐ Never

	O	F	C	N		O	F	C	N
Climbing -	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hand Grasping <u>  R  </u> <u>  L  </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Firm Hand Grasping <u>  R  </u> <u>  L  </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Fine Manipulation <u>  R  </u> <u>  L  </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Gross Manipulation <u>  R  </u> <u>  L  </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Repetitive Motion <u>  R  </u> <u>  L  </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Sitting <u>  R  </u> <u>  L  </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Reaching above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Standing <u>  R  </u> <u>  L  </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Forward reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Stooping <u>  R  </u> <u>  L  </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Walking <u>  R  </u> <u>  L  </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>					

Maximum weight patient is capable of lifting:					Approved Head and Neck Movements:			
1 - 5 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Static Position	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	
6 - 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Frequent Flexing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
11 - 20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Frequent Rotation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
21 - 35 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Can the Patient operate:			
36 - 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	A Motor Vehicle	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	
51 - 75 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hazardous Machine	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
76 - 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Power Tools	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
100 lbs. +	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>				

Limitations to:		Exposure Limitations: Yes No		Yes No	
Speaking _____ hrs.	<input type="checkbox"/>	Heat	<input type="checkbox"/>	Dust	<input type="checkbox"/>
Vision (explain) _____	<input type="checkbox"/>	Cold	<input type="checkbox"/>	Fumes	<input type="checkbox"/>
Depth Perception _____	<input type="checkbox"/>	Dampness	<input type="checkbox"/>	Chemicals	<input type="checkbox"/>
Hearing (explain) _____	<input type="checkbox"/>	Noise	<input type="checkbox"/>	Radiation	<input type="checkbox"/>

Total # of hours patient capable of working per day: 12 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐  
 Duration of restrictions: \_\_\_\_\_ Care Complete: Yes ☐ No ☐ Next Appointment: \_\_\_\_\_  
 Additional Comments: \_\_\_\_\_

Physician's Signature <b>R. James Lentz Jr MD</b>		Date (MM/DD/YYYY) <b>2/28/14</b>
Physician Name <b>R. James Lentz Jr MD</b>		Specialty <b>Orthopedics</b>
Phone Number <b>615-834-4482</b>		Fax Number <b>615-834-4722</b>
Address <b>394 Harding Place Ste 200 Nashville, TN 37211</b>		

WKAB  
GC-1500-26 (7-13)

Page 1 of 2



DCN: 140312082018 PAGE: 003 SEQUENCE: SWF0312201403773001

Claim Number: 9452367

Employee Name (Last, First Middle Initial) Required  
DAVIS, ARTHUR

**Misrepresentation**

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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Employee's Signature

Arthur Cecil Davis Jr.

Date (MM/DD/YYYY)

02/11/2014

WKAB- GC-1500-28 (7-13)

Page 2 of 2



Claim Number: 9452367

**aetna****Attending Physician Statement**

Complete and sign the form using BLUE or BLACK Ink.

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: 800-354-1779  
Fax: 1-866-667-1987

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1. **Patient Instructions** – The Physician will complete Sections 2 through 7.  
The Patient will complete Sections 1 and 8  
The Patient should also fill in their name at the top of Pages 2 and 3.

The **Patient** is responsible for completing this section and for ensuring that their **Attending Physician** completes the remainder of this statement. The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. **If you have any questions, please call 800-354-1779.**

(a) Control Number \_\_\_\_\_

(b) DAVIS, ARTHUR / REDACTED / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Patient Name (Last, First, Middle Initial) Social Security Number Year of Birth Height Weight (lbs)

(c) Patient Gender ☐ Male ☐ Female

(d) Patient Home Address – Required (Current No., Street, Town, State, ZIP – no PO boxes) ☐ Check if New \_\_\_\_\_

(e) Mailing Address, if different from Home Address \_\_\_\_\_

(f) Patient Employer Name/City/State Dell Inc

(g) Patient Telephone Number \_\_\_\_\_ ☐ Check if New

(h) Job Title/Occupation Inside Sales Account Mgmt Iii

(i) Type of Claim: ☐ Short Term Disability ☒ Long Term Disability ☐ Waiver of Premium  
☐ Long Term / Permanent Total Disability

**2. Physician Instructions**

The **Attending Physician** should complete the items below, based upon a recent examination. Attach additional documentation as needed. If you have any questions, please call 800-354-1779.

Please complete form in its entirety and fax to 1-866-667-1987.

Pages 2 and 3 MUST be completed before faxing.

**3. Impairing Diagnosis & Treatment**

(a) For medical reasons, the patient will need to be absent from work due to a disability beginning on 10/11/13 and ending on 05/12/14.  
(MM/DD/YYYY) (MM/DD/YYYY)

(b) Primary Diagnosis rotator cuff tear, left Primary ICD Code 840.4  
Secondary Diagnosis rotator cuff tear, right Secondary ICD Code 840.4  
Other Diagnoses meniscus tears, left knee Other ICD Codes 836.0, 836.1

(c) Height 6'0" Weight 235 Date Measured (MM/DD/YYYY) 12/19/13

(d) If Pregnancy related, delivery or expected due date Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Delivery Type: ☐ Vaginal ☐ Cesarean

(e) Surgery Date 10-11-13 to 1-31-14 Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Primary Procedure left rotator cuff repair Primary CPT Code 79827  
Secondary Procedure right rotator cuff repair Secondary CPT Code 79827  
Other Procedures \_\_\_\_\_ Other CPT Codes \_\_\_\_\_

(f) Medication(s)/Dose/Frequency Percocet, Toradol, prn  
Impairment from medication effects none

(g) Is patient still under your care for this condition? ☒ Yes ☐ No Date service terminated \_\_\_\_\_ (MM/DD/YYYY)

(h) Treatment Summary monthly follow-up, daily physical therapy

(i) Office Visit Dates: First 10/7/13 Last 2/21/14 Next 3/11/14 Frequency of appointments monthly  
(MM/DD/YYYY) (MM/DD/YYYY) (MM/DD/YYYY)

(j) Was patient recently hospitalized? ☒ No ☐ Yes Date hospitalized: Admit: \_\_\_\_\_ Discharge: \_\_\_\_\_ (MM/DD/YYYY) (MM/DD/YYYY)

(k) Hospital Name/City/State \_\_\_\_\_

WKAB- GC-1486-26 (7-13) C R-POD



DCN: 140312082018 PAGE: 007 SEQUENCE: SWF0312201403773001

Claim Number: 9452367

Page 2

Patient Name (Last, First, Middle Initial) Required  
DAVIS, ARTHUR

## 4. History

(a) Symptoms: Pain, decreased motion of both arms

(b) Date symptoms first appeared or accident happened Month 10 Day 11 Year 2013

(c) Has patient ever had same or similar condition? ☒ No ☐ Yes State when and describe.

(e) Is condition due to injury or sickness arising out of patient's employment? ☒ No ☐ Yes ☐ Unknown

(f) Other Treating Physicians

Name _____	Specialty _____	City _____	State _____
Name _____	Specialty _____	City _____	State _____

## 5. Abilities/Limitations

(a) Patient is: Place remarks in item (d) below, if applicable.

- Competent to endorse checks and direct the use of proceeds thereof ☒ Yes ☐ No ☐ Other/describe in (d)
- Able to work with others ☒ Yes ☐ No ☐ Other/describe in (d)
- Able to give supervision ☒ Yes ☐ No ☐ Other/describe in (d)
- Able to work cooperatively with others in group setting ☒ Yes ☐ No ☐ Other/describe in (d)
- Able to do? Select one: Place remarks in item (d) below, if applicable.
  - ☐ Heavy work activity. No limitations of functional capacity.
  - ☐ Medium work activity. Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly.
  - ☐ Light work activity. Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently.
  - ☐ Sedentary work activity. Moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. (Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.)
  - ☒ No ability to work. Severe limitation of functional capacity; incapable of minimal activity.
  - ☐ Other. Place remarks in item (d) below.

(b) What medical restrictions/limitations are you placing on patient? (Activities of Daily Living, Driving, Lifting, Pulling, Pushing, and Amounts, etc.) No use of bilateral upper extremities

• Number of Hours patient is capable of working in a day: ☐ 12 ☐ 10 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐ 1 Hour/Day

• Number of Days per week patient is able to work: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week

• Date you prescribed restriction on work activities: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

• How long are these restrictions/limitations in effect? Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ ☐ No Longer

• Estimated return to work date? \_\_\_\_\_ Modified Duty \_\_\_\_\_ Full Duty \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

(c) Objective findings that substantiate impairment (current laboratory, physical and/or mental status examination and other testing)

(d) Other/Comments

## 6. Current Status

(a) Patient has ☐ Improved ☐ Stabilized ☐ Regressed ☒ Not Applicable

(b) Is there a medical contraindication for patient to participate in Vocational Rehabilitation (job training) programs?  
☒ No ☐ Yes, please explain \_\_\_\_\_

(c) In your opinion, is your patient motivated to return to work? yes

## 7. Physician Information

Attending Physician's Name (Print) <u>R. James Rendra Jr MD</u>	Degree <u>Orthopedics</u>	Specialty <u>MD</u>
Address (No. Street, City, State ZIP Code) <u>394 Harding Pl. Nashville TN 37211</u>	Telephone Number <u>615-834-4482</u>	Fax Number <u>615-834-4722</u>
Signature <u>[Signature]</u>	Date (MM/DD/YYYY) <u>2/28/14</u>	

WKAB  
GC-1486-26 (7-13) C



Claim Number: 9452367

Patient Name (Last, First, Middle Initial) Required  
DAVIS, ARTHUR

### 8. Regulation Notice

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

WKAB  
GC-1486-26 (7-13) C

Page 3





## Fax Message

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**To:** scanning  
**Fax:** 8666671987  
**From:** Amor, Maribel  
**Date:** 3/7/2014 9:23 AM  
**Pages:** 1 of 4 (including this page)  
**Subject:** e-mail response to claimant

---

**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.



Claim 9452367

*Maribel Amor, MST*  
*Senior Disability Benefit Manager*  
*Aetna Life Insurance Company*  
*Ph: 954-693-2140*  
*Fax: 860-907-4494*  
*E-mail: AmorM@Aetna.com*

**Amor, Maribel**

---

**From:** Amor, Maribel  
**Sent:** Friday, March 07, 2014 9:07 AM  
**To:** 'Art Davis'  
**Subject:** RE: Response to your query

Hi Mr. Davis:

Please provide with the name, address , phone and fax for your new provider. Thanks, Maribel

Maribel Amor, MST  
Senior Disability Benefit Manager  
Aetna Life Insurance Company  
Ph: 954-693-2140  
Fax: 860-907-4494  
E-mail: [AmorM@Aetna.com](mailto:AmorM@Aetna.com)

**From:** Art Davis [mailto:REDACTED]  
**Sent:** Friday, March 07, 2014 9:05 AM  
**To:** STD\_LOA  
**Cc:** Amor, Maribel  
**Subject:** RE: Response to your query

Good morning it appears Dr. Cote does not do disability paperwork. I will request my medical records be faxed to you Maribe. I am going to a Pain Specialist this morning. The 6 weeks of physical therapy has not reduced the back pain.

**From:** [STD\\_LOA@aetna.com](mailto:STD_LOA@aetna.com) [mailto:STD\_LOA@aetna.com]  
**Sent:** Thursday, March 06, 2014 12:38 PM  
**To:** REDACTED  
**Cc:** [AmorM@Aetna.com](mailto:AmorM@Aetna.com)  
**Subject:** Response to your query

RE: Records needed

Dell Inc  
03/06/2014

Dear Mr. Davis:

We have requested Dr. Cote's medical records and the completion of forms but we have not received a response. Please have Dr. Cote complete the attached forms and submit all the available medical records from Dr. Cote. Thanks, Maribe

Please let us know if we can provide additional assistance.

Thank you,

Aetna Disability and Absence Management Services

Aetna Fax #: 1-866-667-1987

Visit us on the Web: <https://www.aetnadisability.com>

This e-mail may contain confidential or privileged information. If you think you have received this e-mail in error, please advise the sender by reply e-mail and then delete this e-mail immediately. Thank you. Aetna



687103

**aetna**<sup>SM</sup>

## Fax Message

---

**To:** Dr. Renfro

**Fax:** 615-834-4722

**From:** Amor, Maribel

**Date:** 2/26/2014 2:41 PM

**Pages:** 1 of 8 (including this page) 10

**Subject:** Request for medical information

---

**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

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PO Box 14560  
Lexington, KY 40512-4560  
800-354-1779

## Facsimile Transmittal Sheet

To:	From:
Dr. Renfro	MARIBEL AMOR
Employer:	Date:
Dell Inc	02/26/2014
Fax Number:	CLAIM NUMBER:
615-834-4722	9452367
Phone number:	Sender's Phone Number:
	800-354-1779
	Sender's FAX Number:
	1-866-667-1987
Re: MR. ARTHUR DAVIS	Total No. of Pages Including Cover:
Date of Birth: REDACTED	

☐ Urgent ☐ For Review ☐ Please Comment ☒ Please Reply ☐ Please Recycle

Dear Dr. Renfro:

Please complete the attached form and provide us with all the progress notes, evaluations for February 2014.  
Thanks, Maribel

Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you received this communication in error, please notify the sender at the phone number above.

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Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

The information contained in this document is CONFIDENTIAL. If you have received this in error, please fax immediately to 1-866-667-1987. Thank you.

Enclosed:  
Attending Physician Statement

## Progress Note

Patient Name: Arthur Davis, Jr.

Patient ID: 687103

Sex: Male

Birthdate: REDACTED

Primary Care Provider: Tadayuki Yoneyama MD

Referring Provider: Former Patient

Visit Date: February 11, 2014

Provider: R. J. Renfro, MD

Location: Harding Place

Location Address: 394 Harding Place Suite 200  
Nashville, TN 372113980

Location Phone: (615) 834-4482

**Chief Complaint**

- left shoulder
- right shoulder

**History Of Present Illness**

Arthur C. Davis Jr. is a 50 year old Black/African American male who presents today for

Followup of his right shoulder surgery. His wounds look good. Sutures removed. We discussed the massive tear with him. He is to work on pendulum exercises and passive motion exercises and we'll see him back in 1 month.

**Past Medical History**

Disease Name	Date Onset	Notes
Asthma	--	--
Degeneration of lumbar intervertebral disc	11/07/2013	--
High blood pressure	--	--
Rotator Cuff Sprain/Tear	10/07/2013	--
Rotator Cuff Tear, Non-Trauma	10/07/2013	--
Sclatica	11/02/2013	--
Sprain/Strain	10/18/2013	--
Sprain/Strain, Lumbar	10/18/2013	--
Tear, Medial Meniscus	01/28/2014	--

**Past Surgical History**

Procedure Name	Date	Notes
Hernia	--	--
Joint surgery (arthroscopic or open)	2004	left knee
Sinus Surgery	--	--

**Medication List**

Name	Date Started	Instructions
Advair Diskus Inhalation disk with device 250-50 mcg/dose	07/19/2013	--
amlodipine Oral tablet 10 mg	09/10/2013	--
Celebrex Oral capsule 200 mg	07/12/2013	--
ciprofloxacin Oral tablet 500 mg	07/11/2013	--
clotrimazole-betamethasone Topical cream 1-0.05 %	08/13/2013	--
fluticasone Nasal spray,suspension 50 mcg/actuation	07/19/2013	--
lisinopril-hydrochlorothiazide Oral tablet 20-25 mg	09/23/2013	--
methylprednisolone Oral tablets,dose pack 4 mg	09/19/2013	--
metoprolol succinate Oral tablet extended release 24 hr 50 mg	07/31/2013	--
naproxen Oral tablet 500 mg	09/27/2013	--

[Digital Signature Validated]

Neurontin oral capsule 300 mg	12/19/2013	1 capsule (300 mg) by oral route every eight hours for 30 days
omeprazole Oral capsule, delayed release (DR/EC) 20 mg	07/19/2013	--
potassium chloride Oral tablet extended release 10 mEq	08/06/2013	--
prednisone Oral tablet 20 mg	09/27/2013	--
splironolactone Oral tablet 25 mg	08/13/2013	--
Ultram Oral tablet 50 mg	11/06/2013	take 1 tablet (50 mg) by oral route every 6 hours as needed for 15 days

**Allergy List**

Allergen Name	Date	Reaction	Notes
codeine sulfate	--	itching/rash	--

**Family Medical History**

Disease Name	Relative/Age	Notes
Family history of arthritis	/ Mother/	--
Family history of heart disease	/ Mother/	--

**Social History**

Finding	Status	Start/Stop	Quantity	Notes
Alcohol Intake	Never	--/--	--	--
Tobacco	Never	--/--	--	--

**Review of Systems****Constitutional**

- Denies : fatigue, weight loss, weight gain

**Gastrointestinal**

- Denies : heartburn, hematemesis

**Genitourinary**

- Denies : dysuria

**Neurologic**

- Denies : muscular weakness, incoordination, tingling or numbness, loss of balance

**Musculoskeletal**

- Admits : joint pain, night pain

**Psychiatric**

- Denies : depression

**Vitals**

Date	Time	BP	Position	Site	L/R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m <sup>2</sup>	BSA m <sup>2</sup>	O2 Sat	HC
12/19/2013	03:05 PM							18		236lbs 0oz	6' 0"	32.01	2.33		

**Assessment**

- Rotator Cuff Sprain/Tear 840.4
- Rotator Cuff Tear, Non-Trauma 727.61

[Digital Signature Validated]

**Plan**

**Instructions**

- o This note was generated using EMR and voice recognition software and therefore may contain unedited errors.

**Disposition**

- o Instructed on home exercises
- o RTC in 4 weeks

**Electronically Signed by:** R J. Renfro, MD -Author on February 11, 2014 02:34:36 PM

[Digital Signature Validated]



Claim Number: 9452367

**aetna**

**Attending Physician Statement –**  
**Musculoskeletal: Orthopaedic Surgery,**  
**Spinal Surgery, Physiatry, Podiatry, Chiro**

Aetna Life Insurance Company  
 PO Box 14560  
 Lexington, KY 40512-4560  
 Phone: 800-354-1779  
 Fax: 1-866-667-1987

**1. Patient Information**

Name <u>Arthur Davis</u>		Employer Name		Job Title	
Year of Birth	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No	Height (ft/in.)	Weight (lbs.)	BMI
Blood Pressure		Date Measured			

**2. Physician Information**

Name <u>R. James Rensford Jr M.D.</u>		Specialty <u>Orthopaedics</u>
Tax I.D. Number	Telephone Number (include area code) <u>615-834-4482</u>	Fax Number (include area code) <u>615-834-4722</u>

**3. Management Information**

Disability Benefits Manager <u>MARIBEL AMOR</u>	Telephone Number (include area code) <u>800-354-1779</u>	Fax Number (include area code) <u>1-866-667-1987</u>
--	---	---

**4. Treatment Information**

First Day recommended out of Work <u>10-11-13</u>	Initial Treatment Date <u>10-7-13</u>	Last Appointment Date <u>2-21-14</u>	Surgery Date <u>10-11-13 ; 1-31-14</u>
Medication (Name, Dosage and Frequency) <u>Percocet, Toradol PRN</u>			
Hospitalized <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Recent Hospitalization Admitted on <u>1/1/14</u>	Discharged on <u>1/1/14</u>	Recent Surgery Date (MM/DD/YYYY) <u>1/31/14</u>

**5. Clinical Condition**

Diagnosis <u>rotator cuff tears</u>	ICD9 Code(s) <u>727.61</u>	Procedure (if applicable) <u>RCR x 2</u>	CPT Code(s) <u>29827</u>
Is this condition responsible for any functional impairment? <input type="checkbox"/> Yes, complete Sections 6, 7, 8 and 9 <input checked="" type="checkbox"/> No, provide a release to full duty in Section 9			
Is the condition work related? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, Date of Injury / Illness <u>1/1/14</u>	

**6. Treatment Plan**

Facility Name <u>Surgene Premier Orthopaedics Surgery Center</u>	Telephone Number (include area code) <u>615-332-3600</u>
Address (include Zip Code) <u>394 Harding Place Nashville TN 37211</u>	

**7. Objective Data that documents a functional impairment**

Please record vital signs and describe physical exam (Quantitative ROM, Gait, Motor/Sensory/DTR, Neuro Findings, Effusions, Girth of Extremities) or WNL <u>↓ ROM,</u>
Diagnostic Tests (X-Rays, CT/MRI, Myelogram, Discogram, Arthrogram, EMG/NCV, Bone Scans, Lab Test, etc.) or WNL <u>MRI's reveal tears</u>
Other (PT/OT status, Pre & Post Surgical Indications and/or complications) or WNL <u>P.T. 3-4 weeks</u>

**8. Work Restrictions**

--

**9. Return to Work Status**

<input type="checkbox"/> Able to return to full duty on (date): <u>1/1/14</u>
<input type="checkbox"/> Able to work with restrictions. Can return to work on (date): <u>1/1/14</u> Work restrictions will apply until (date): <u>1/1/14</u>
<input checked="" type="checkbox"/> I am unable to release this patient. I anticipate significant clinical improvement by date: <u>5/12/14</u> Next appointment (date): <u>3/11/14</u>

**10. Signature**

Physician's Signature <u>R. James Rensford Jr MD</u>		Date (MM/DD/YYYY) <u>1/1/14</u>
Physician Name: <u>R. James Rensford Jr MD</u>	Specialty: <u>Orthopaedics</u>	
Phone Number:	Fax Number:	
Address:		

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. *Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.*

WKAB-GR-00332 (7-13)





PO Box 14560  
Lexington, KY 40512-4560  
MARIBEL AMOR  
Senior LTD Claim Analyst  
Phone: 800-354-1779  
Fax: 1-866-667-1987

02/05/2014

ARTHUR DAVIS

**REDACTED**

MURFREESBORO TN - 37128

**Group Control No:**

**Employer:** Dell Inc  
**Employee:** MR. ARTHUR DAVIS  
**Disability Claim Case No:** 9452367

Dear MR. DAVIS:

Aetna Life Insurance Company ("Aetna") administers leaves of absence for Dell Inc under applicable state law and Dell Inc leave policies.

This letter concerns your disability plan with the above employer.

Our records indicate that you will soon reach the maximum number of weeks for short-term disability benefits under your plan. Please consult your Employee Booklet or Summary Plan Description to determine the maximum number of weeks that benefits are payable.

Please be sure to notify us as soon as possible if you return to work.

We are reviewing your claim to determine your eligibility for long-term disability (LTD) benefits. Certification of your short-term disability does not guarantee payment of LTD benefits. We will notify you shortly regarding the status of your LTD claim.

You previously received correspondence indicating your certified length of disability. As you may now be eligible for long-term disability benefits, we will periodically contact you for information to assess your continued disability.

At this time, we need you to complete, sign and return the forms below to Aetna within thirty (30) days from the date of this letter.

- **Aetna to Request Protected Health Information (PHI)**

In signing this form you authorize Aetna to obtain Protected Health Information necessary to process your disability claim.

- **Other Income Questionnaire**

This form shows types and amounts of "other income" benefits that you may now receive or may be eligible to receive. Please list all such other income benefits that you are now receiving or may be eligible to receive.

- **Authorization to Obtain Information**

In signing this form you authorize Aetna to obtain non-medical information from any agency or institution.

- **Work History and Education Questionnaire**

This form allows Aetna to assess your education and work history. Also, the form authorizes us to obtain and release information from past and present employers.

- **Reimbursement Agreement**

In signing this form, you authorize Aetna to recover any overpayments resulting from a retroactive Social Security benefit or from any other income source listed on the Disability Income Questionnaire.

Claim Number: 9452367

<b>Form W-4S</b> Department of the Treasury Internal Revenue Service		<b>Request for Federal Income Tax Withholding From Sick Pay</b> ▶ Give this form to the third-party payer of your sick pay. ▶ Information about Form W-4S is available at <a href="http://www.irs.gov/w4s">www.irs.gov/w4s</a> .		OMB No. 1545-0074 <b>2014</b>
Type or print your first name and middle initial. <b>ARTHUR C.</b>		Last name <b>DAVIS Jr.</b>		Your social security number <b>REDACTED</b>
Home address (number and street or rural route) <b>REDACTED</b>				
City or town, state, and ZIP code <b>Murfreesboro, TN 37128</b>				
Claim or identification number (if any)				
I request federal income tax withholding from my sick pay payments. I want the following amount to be withheld from each payment. (See <b>Worksheet</b> below.)				\$
Employee's signature ▶ <b>Arthur C Davis Jr</b>				Date ▶ <b>2/26/14</b>

Separate here and give the top part of this form to the payer. Keep the lower part for your records.

**Worksheet** (Keep for your records. Do not send to the Internal Revenue Service.)

1	Enter amount of adjusted gross income that you expect in 2014	1	36,000	-
2	If you plan to itemize deductions on Schedule A (Form 1040), enter the estimated total of your deductions. For 2014, you may have to reduce your itemized deductions if your income is over \$305,050 and you are married filing jointly or are a qualifying widow(er); \$279,650 if you are head of household; \$254,200 if you are single and not head of household or a qualifying widow(er); or \$152,525 if you are married filing separately. See Pub. 505 for details. If you do not plan to itemize deductions, enter the standard deduction. (See the instructions on page 2 for the standard deduction amount, including additional amounts for age and blindness.)	2	6100	
3	Subtract line 2 from line 1	3	29,900	-
4	Exemptions. Multiply \$3,950 by the number of personal exemptions	4	3,950	
5	Subtract line 4 from line 3	5	25,950	-
6	Tax. Figure your tax on line 5 by using the 2014 Tax Rate Schedule X, Y, or Z on page 2. Do not use the Tax Table or Tax Rate Schedule X, Y, or Z in the 2013 Form 1040, 1040A, or 1040EZ instructions	6	2531	25
7	Credits (child tax and higher education credits, credit for child and dependent care expenses, etc.)	7	-	
8	Subtract line 7 from line 6	8	2531	25
9	Estimated federal income tax withheld or to be withheld from other sources (including amounts withheld due to a prior Form W-4S) during 2014 or paid or to be paid with 2014 estimated tax payments	9	-0-	
10	Subtract line 9 from line 8	10	2531	25
11	Enter the number of sick pay payments you expect to receive this year to which this Form W-4S will apply	11	8	
12	Divide line 10 by line 11. Round to the nearest dollar. This is the amount that should be withheld from each sick pay payment. Be sure it meets the requirements for the amount that should be withheld, as explained under <b>Amount to be withheld</b> below. If it does, enter this amount on Form W-4S above	12	316	41

**General Instructions**

**Purpose of form.** Give this form to the third-party payer of your sick pay, such as an insurance company, if you want federal income tax withheld from the payments. You are not required to have federal income tax withheld from sick pay paid by a third party. However, if you choose to request such withholding, Internal Revenue Code sections 3402(o) and 6109 and their regulations require you to provide the information requested on this form. Do not use this form if your employer (or its agent) makes the payments because employers are already required to withhold federal income tax from sick pay.

**Note.** If you receive sick pay under a collective bargaining agreement, see your union representative or employer.

**Definition.** Sick pay is a payment that you receive:

- Under a plan to which your employer is a party and
- In place of wages for any period when you are temporarily absent from work because of your sickness or injury.

**Amount to be withheld.** Enter on this form the amount that you want withheld from each payment. The amount that you enter:

- Must be in whole dollars (for example, \$35, not \$34.50).
- Must be at least \$4 per day, \$20 per week, or \$88 per month based on your payroll period.

- Must not reduce the net amount of each sick pay payment that you receive to less than \$10.

For payments larger or smaller than a regular full payment of sick pay, the amount withheld will be in the same proportion as your regular withholding from sick pay. For example, if your regular full payment of \$100 a week normally has \$25 (25%) withheld, then \$20 (25%) will be withheld from a partial payment of \$80.

**Caution.** You may be subject to a penalty if your tax payments during the year are not at least 90% of the tax shown on your tax return. For exceptions and details, see Pub. 505, *Tax Withholding and Estimated Tax*. You may pay tax during the year through withholding or estimated tax payments or both. To avoid a penalty, make sure that you have enough tax withheld or make estimated tax payments using Form 1040-ES, *Estimated Tax for Individuals*. You may estimate your federal income tax liability by using the worksheet above.

**Sign this form.** Form W-4S is not valid unless you sign it.

**Statement of income tax withheld.** After the end of the year, you will receive a Form W-2, *Wage and Tax Statement*, reporting the taxable sick pay paid and federal income tax withheld during the year. These amounts are reported to the Internal Revenue Service.

(continued on back)

For Paperwork Reduction Act Notice, see page 2.

Cat. No. 10226E

Form **W-4S** (2014)

Claim Number: 9452367

Employee Name (Last, First Middle Initial)  
DAVIS, ARTHUR

Employee Social Security Number  
REDACTED

### Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Employee's Signature

*Arthur C Davis*

Date (MM/DD/YYYY)

02/11/2014

WKAB  
GC-1501-26 (7-13)

Page 3 of 3



0220140004

Claim Number: 9452367

# aetna

## Work History and Education Questionnaire

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: 800-354-1779  
Fax: 1-866-667-1987

Instructions: Please print, answer all questions, date and sign the release. Complete and sign the form using BLUE or BLACK ink.

<b>1. Employee Information</b>	Name (Last, First, Middle Initial) <b>DAVIS, ARTHUR</b>		Social Security Number <b>REDACTED</b>	
	Control Number <b>REDACTED</b>	Year of Birth <b>REDACTED</b>	Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	
<b>2. Education</b>	Highest Level Achieved			
	Grade <input type="checkbox"/> 1-8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> GED College <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4			
	Post Graduate Work			
	List Degrees, Majors <b>Associates Degree Business Management</b>			
	List Any Additional Training			
<b>3. Work History</b>	Current Job You Are Disabled From <b>Inside Sales Manager</b>		Date Hired (MM/DD/YYYY) <b>05/22/2006</b>	
	Salary <b>\$58,000</b>			
	Description of Your Job (e.g., Tasks/Functions Performed; Include: Equipment, Tools, Applications, Time Demands, Mental Demands, Stress Level) <b>Responsible for 100 or more dedicated accounts. Solicit IT solutions including computer equipment and services. Responsible for maintaining phone activity and required quota. High stress, high blood pressure.</b>			
	List Those Duties You Now Cannot Perform <b>Sitting in office chair is very painful. My back has constant pain from back of head to tailbone. I have difficulty driving, turning my head and controlling steering wheel with use of left hand. Partial use of right hand very limited.</b>			
	Supervision of Others <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Number of Hours in Your Workday <input type="checkbox"/> 8 <input type="checkbox"/> 10 <input checked="" type="checkbox"/> 12 Other _____	
Other Job Titles Held: <b>Consumer Sales</b>				
In Your Work Day, How Much Time (Hours) Did You Spend:				
A. Sitting <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input checked="" type="checkbox"/> Continuously				
B. Standing <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> Continuously				
C. Walking <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> Continuously				
On The Job You:				
1. Bend/Stoop <input checked="" type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Continually				
2. Crawl <input checked="" type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Continually				
3. Reach Above Shoulders <input checked="" type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Continually				
4. Kneel <input checked="" type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Continually				
5. Push/Pull <input checked="" type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Continually				
6. Lift Up To 10 Pounds <input checked="" type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Continually				
11-25 Pounds <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Continually				
26-50 Pounds <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Continually				
50 Pounds or More <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Continually				
Do You Use Your Hands And/Or Feet For Repetitive Movements? (E.G. Operating Foot Controls)				
Right Hand: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Right Foot: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Left Hand: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Left Foot: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

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Claim Number: 9452367

Employee Name (Last, First, Middle Initial) DAVIS, ARTHUR	Employee Social Security Number REDACTED
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Please provide complete work history information for the past 15 years (list chronologically and use additional paper if necessary).

4. Other Work History	Employer First TN Bank	Job Title Financial Svc Rep	Employed From Apr 04 to Dec 06	Salary 31,000
	Description of your job Sold FDIC and Non FDIC products to bank customers.			
	Training Received Series 7 licensed			
	Equipment, Tools, Applications, Time Demands, Mental Demands, Stress Level Computers and pen and paper. Minimum stress mental demands			
	Supervision of others as part of your job <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	Employer Woodbury Financial	Job Title Agent	Employed From Jan 02 to Apr 04	Salary 25,000
	Description of your job Sold life insurance and investments to individuals & small business			
	Training Received NA			
	Equipment, Tools, Applications, Time Demands, Mental Demands, Stress Level Computer, pen and paper Minimum stress mental demand			
	Supervision of others as part of your job <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	Employer H H Gregg	Job Title Sales Assoc	Employed From Dec 01 to July 03	Salary \$60,000
	Description of your job Sold electronics to individuals			
	Training Received Products and Services			
	Equipment, Tools, Applications, Time Demands, Mental Demands, Stress Level TV, stereos, accessories			
	Supervision of others as part of your job <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Please list your outside of work activities (e.g. Sports, Activities, Hobbies)

5. Additional Information	Before your Disability: Coached youth Football, involved in all aspects from assistant to head coach. Spin class 2x a day, Yoga, Landscaping Boot camps, weight training
	After your Disability: Physical therapy

6. Certification	I hereby certify that the foregoing statements and answers are complete and true to the best of my knowledge and belief. Date (MM/DD/YYYY) 02/11/14 Signed Employee Arthur C Day
------------------	---

7. Authorization	To my present employer and all previous employers: I hereby authorize my present and past employers to provide Aetna or its representative with a description of all job-related duties and functions I performed while actively employed. I further authorize Aetna or its representative to release this information to vocational or clinical specialists it utilizes during the course of its administration of my disability claim. A copy of this authorization shall be as valid as the original. Date (MM/DD/YYYY) _____ Signed Employee _____
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0220140004

Claim Number: 9452367

# aetna<sup>®</sup> Authorization For Aetna To Request Protected Health Information Necessary To Process A Disability Claim

Please Read The Following Carefully Before Completing Your Authorization. You May Refuse To Sign This Authorization. (See Section 6.)

**1. Member Information (Information About Person For Whom This Authorization Is Requested.)**

Last Name DAVIS	First Name ARTHUR	Middle Initial C
Claim Number 9452367	Year of Birth [REDACTED]	Daytime Telephone Number (include area code) [REDACTED]
Street Address [REDACTED]	City, State and ZIP Murfreesboro, TN 37128	

**2. This form requests a Member's unconditioned authorization for Aetna to ask another person or organization to disclose Member's Protected Health Information ("PHI") to Aetna for the purpose of processing my disability claim.**

**3. The specific PHI we are asking you to authorize Aetna to request is (This section completed by Aetna.)**

Any and all medical information including but not limited to information which relates to psychiatric or mental health, drug, substance abuse, and/or HIV Infection, including AIDS and related illnesses, concerning health care, advice and treatment and prescription history records (including but not limited to, medical records, histories, physical or diagnostic examinations reports and treatment notes).

**4. If you prefer to authorize the request of only selected categories of information, please indicate below which types of information may be disclosed. (This section completed by Member)**

<input type="checkbox"/> Health (This includes medical, dental, pharmacy, vision, and flexible spending account information)
<input type="checkbox"/> Behavioral Health (e.g., mental health, drug and alcohol abuse treatment)
<input type="checkbox"/> Disability <input type="checkbox"/> Life Insurance <input type="checkbox"/> Long Term Care <input type="checkbox"/> Workers' Compensation
<input type="checkbox"/> Other: (please specify) _____

**5. By signing this form, you will authorize Aetna to request PHI described above from the following persons or organizations (or classes of persons or organizations.)**

Service Providers, including but not limited, to physicians, therapists, medical practitioners, health care professionals, workers' compensation professionals, diagnostic facilities, hospitals, clinics and pharmacy related service organizations (including individuals or facilities which provide rehabilitation services or treatment).

**6. Expiration of this Authorization**

This authorization is valid throughout the processing and any term of your disability claim unless you indicate a shorter period below.

\_\_\_\_\_ through \_\_\_\_\_  
mm/dd/yyyy mm/dd/yyyy

Please review and complete important information on the reverse of this form.

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Claim Number: 9452367

Employee Name  
ARTHUR DAVIS

**7. Important: Your signature below means that you understand and agree to the following:**

- You authorize Aetna to request from the persons or organizations named above, the PHI described above, for the purposes stated above.
- The information to be disclosed may be protected by law. Information disclosed under this authorization may be re-disclosed and no longer protected by federal privacy regulations.
- Failure to complete this form may prevent Aetna from receiving information necessary for the processing of your disability claim, which may result in a disability claim denial. Failure to complete this form will not however impact your receipt of medical services from providers.
- You may revoke this Authorization at any time by notifying Aetna in writing, but please note that actions Aetna has taken before we received your revocation will still be valid under this authorization.
- You may receive a copy of this form if you request it in writing from the address listed below.

**8. Signature of Member or Legal Representative**

Signature of Member or Legal Representative <i>Arthur C Davis Jr.</i>	Date 02/11/2014
Print Name Arthur C Davis, Jr.	

If not the Member, describe your relationship to the Member:

- ☐ Caregiver  
☐ Legal Representative  
☐ Other: \_\_\_\_\_

If Member's legal representative is signing this Authorization, you must furnish a copy of the health care power of attorney, or other relevant document designating you as the representative.

**NOTICE TO RECIPIENT(S) OF INFORMATION (Section 2. above):**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

Return this completed form to: **Aetna Life Insurance Company**  
PO Box 14560  
Lexington, KY 40512-4560

Telephone Number: 800-354-1779  
Fax Number: 1-866-667-1987

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GR-67940-26 (8-13) D

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Claim Number: 9452367

Employee Name  
DAVIS, ARTHUR

#### 9. Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

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GR-67940-26 (8-13)

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Claim Number: 9452367



## Authorization to Share and Use Medical Information

Mail this completed form to:  
Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Fax: 1-866-667-1987

I allow all doctors, hospitals, other health care providers, pharmacy, pharmacy benefit managers, government agencies, insurers, employers, schools, training facilities, health plans, policyholders, contract holders, vendors, health and benefit plan administrators or their successors ("Records Holders") to give out my medical information as explained on this Authorization form.

This information includes, but is not limited to, any records or facts about my medical condition, treatment, supplies, employment, vocation, education training, income, and other insurance coverage including benefits paid ("Information"). This Information may also include diagnosis, treatment and education related to drug and/or alcohol abuse, HIV/AIDS or other communicable or sexually-transmitted disease, as well as behavioral health conditions (but does not include psychotherapy notes).

I allow the Records Holders to give my Information to the following individuals or entities ("Benefit Managers"): the employer named below, Aetna Life Insurance Company, their benefit plan or claims administrator(s), their related companies, contractors, investigators, attorneys, and service consultants, authorized union representatives, health care providers treating or evaluating me or my claim, and other individuals or entities involved in administering, evaluating, analyzing and managing the plan or my claim.

I allow the Benefit Managers to use and give out the Information only to evaluate, analyze, manage and/or administer a claim for short term disability benefits, long term disability benefits, salary continuation, leave under the federal Family and Medical Leave Act, local and state leave laws, workers' compensation and/or any other health benefit program, fitness for duty, other work accommodation programs, or leave benefits offered by and through my employer ("Benefits Program"). I also allow the Benefits Managers to give my Information to any other person or entity if needed to find out whether I am eligible for benefits, to manage my claim, or to run the Benefits Program.

I understand that Information disclosed to Benefit Managers pertaining to certain alcohol or drug abuse treatment or HIV/AIDS or other communicable or sexually-transmitted disease is protected by federal (42 CFR Part 2) and state confidentiality rules and statutes, which prohibit any further disclosure of this information without my express written consent, or as otherwise permitted by such rules and statutes. I understand that a general authorization for the release of medical or other information is NOT sufficient for release of these types of records. Therefore:

☒ If any of my records contain information about alcohol or drug abuse, then, by checking this box, I hereby expressly allow my Benefits Managers to use or give out such information to evaluate, analyze, manage and/or administer the Benefits Program. I understand that the federal rules restrict any use of the Information to criminally investigate or prosecute any drug or alcohol abuse patient.

☒ If any of my records contain information about HIV/AIDS or other communicable or sexually transmitted disease, then, by checking this box, I hereby expressly allow my Benefits Managers to use or give out such information to evaluate, analyze, manage and/or administer the Benefits Program.

The Benefits Managers will tell those receiving Information that the Information is confidential. The Information provided to Aetna will not be used for any purpose other than its intended use stated above. I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it and it may be re-disclosed by the Benefit Managers.

Unless revoked earlier, I understand that this permission lasts twelve (12) months after my claim is processed or twelve (12) months after the end of my coverage under the Benefits Program, whichever is longer, unless law requires a shorter period. If I change my mind about this Authorization before that time is up, I can tell my Records Holders and Benefits Managers in writing that I do not want them to share any more information. If I revoke my Authorization by telling them in writing to stop sharing information, it will not change any actions they took before I revoked my permission. If I do not sign this Authorization, it will not affect how my health care providers treat me. However, if I do not sign, the Benefits Managers may not be able to review my claim and cannot find out whether I am eligible for benefits. This may result in denial of my request for benefits.

The Information released under this Authorization can be submitted to the Benefits Managers electronically, by phone or fax, or by mail. I know I can see or copy the records given to the Benefits Managers. I agree that a copy of this Authorization may be treated as a signed original.

### NOTICE TO RECIPIENT(S) OF INFORMATION:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.

Claimant's Name <b>Arthur C Davis, Jr.</b>	Date of Birth <b>REDACTED</b>	Date <b>02/11/2014</b>
Claimant's or Legal Representative's Signature <b>Arthur C Davis</b>	Legal Representative's Name and Relationship	
Employer's Name <b>Dell Inc.</b>		

WKAB

GR-68320 (6-13) 1

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Claim Number: 9452367



## Other Income Questionnaire Disability Benefits

Mail this completed form to:  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: 800-354-1779  
Fax: 1-866-667-1987

- Please complete this form immediately so we can accurately determine your benefits.
- Provide all information relating to your actual or expected entitlement to income from all sources (excluding Aetna Disability Benefits) to avoid processing delays and/or overpayment of benefits.
- **Please check all boxes that apply.**
- Complete and sign the form using BLUE or BLACK ink.

Employee's Name (Last, First, Middle Initial) <b>DAVIS, ARTHUR</b>		Claim Number
Control Number	Employee Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Year of Birth <b>REDACTED</b>

**This section must be completed:**

Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> Widowed If married, spouse's date of birth (MM/DD/YYYY) _____	
Do you have any dependent children? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, youngest child's date of birth (MM/DD/YYYY) <u>02/11</u> <b>REDACTED</b>	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No I am currently receiving other income.	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No I have received other income since the onset of my disability.	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No I have received income from work activity since the onset of my disability.	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No I have applied for and/or received other income as defined below.	
Provide information as to all of the following types and/or sources of other income: <ul style="list-style-type: none"><li>• Salary/Wages from present employer</li><li>• Income from self-employment</li><li>• Rehabilitation Earnings</li><li>• Pension/Retirement (including Canada)</li><li>• Part-time Earnings</li><li>• Veteran's Benefits</li><li>• Unemployment Compensation</li><li>• Jones Act or Maritime Doctrine</li><li>• Recoveries from Third Party causing disability</li><li>• Social Security Disability - Primary</li><li>• Social Security Disability - Family</li><li>• Social Security Retirement</li><li>• Social Security Widow/Widowers Benefit</li><li>• State Disability Plans</li><li>• Workers' Compensation - Periodic/Lump Sum</li><li>• No-Fault Automobile Coverage</li><li>• Railroad Retirement</li><li>• Private Group Disability benefits</li></ul>	

List other income you are receiving or have applied for:		
Source of Income	Effective Date of Benefits (MM/DD/YYYY)	Benefit Amount and Frequency

Signature <i>Arthur C Davis</i>	Date (MM/DD/YYYY) <u>02/11/2014</u>
------------------------------------	--

WKAB

GC-1503-26 (8-13) C

Complete back →

R-POD



Claim Number: 9452367

Employee's Name (Last, First, Middle Initial)  
DAVIS, ARTHUR

### Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Employee's Signature

Arthur C Davis

Date (MM/DD/YYYY)

02/11/2014

WKAB  
GC-1503-26 (8-13) C

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Claim Number: 9452367



## Authorization for EFT/Direct Deposit of Disability Benefit Payment

It's easy to set up EFT payments for disability benefits. All you have to do is complete the form below or you may visit us at <https://www.aetnadisability.com>. If you would prefer to complete via the form please sign and return the form to Aetna at the address below or you may also fax your information to 1-866-667-1987.

Aetna Life Insurance Company (Aetna)  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: 800-354-1779  
Fax: 1-866-667-1987

☒ New ☐ Change ☐ Cancel

### Employee Information - ALL fields must be completed.

Name	Arthur C Davis, Jr.			Telephone	REDACTED
Street Address	REDACTED				
City	MarFreesboro	State	TN	ZIP Code	37128
Social Security Number	REDACTED				

### Banking Information - ALL fields must be completed.

Name of Financial Institution	US Bank	Telephone	(800) 872-2657
Please indicate: <input checked="" type="checkbox"/> Checking <u>OR</u> <input type="checkbox"/> Savings <u>and</u>			
ATTACH a copy of a blank check, marked "VOID OR provide the information below:			
Routing Number:		REDACTED	
Account Number:		REDACTED	

ATTACH HERE

ARTHUR C. DAVIS JR CAROLYN D. MCCAIN-DAVIS FRANKLIN, TN 37064		87-5-640	886
Pay To The Order Of		\$	
VOID		Dollars	
USBANK FIVE STAR SERVICE GUARANTEED USBANK.COM		MP	
For		REDACTED	
Authorized Signature(s)		Date	
Arthur C Davis Jr		2/11/2014	

EFT GR-68735 (2-12) C

R-POD



0220140004

Claim Number: 9452367



## Authorization To Obtain Information

Complete and sign the form using BLUE or BLACK ink.

Control Number: \_\_\_\_\_

Employee Year of Birth: \_\_\_\_\_

Employee Gender: ☒ Male ☐ Female

I DAVIS, ARTHUR, Claim Number \_\_\_\_\_  
(please print full name – Last, First, Middle Initial)

hereby authorize any insurance company, third party administrator, government organization, employer and any of their agents performing services relating to any employee benefits or workers compensation or other organization, institution, or person that has any records or knowledge about me containing the following to release the information to the Aetna and/or its duly authorized representatives or agents:

- Financial information,
- Information pertaining to my credit history,
- Information pertaining to my academic performance, credits earned, or school-related activities,
- Other insurance benefits, or,
- Employment information and history (including job duties and earnings).

I understand that the information obtained by use of this authorization will be used for the purpose of evaluating and administering my claim for disability benefits.

This authorization is valid for the term of the policy or contract under which a claim has been submitted.

I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

I further authorize the Aetna and/or its authorized representatives or agents to request reports and information from the Social Security Administration regarding benefits, earnings and employer information, and any award, disallowance or termination relating to benefits.

Print Name (Last, First, Middle Initial) <u>Davis Arthur, C</u>	
Signature of Employee <u>Arthur Cyril Davis Jr.</u>	Date Signed (MM/DD/YYYY) <u>02/11/2014</u>

If the person signing this authorization is not the member, describe relationship to the member.

If this authorization is being signed by the member's legal representative, you must furnish a copy of the Power of Attorney or other relevant document authorizing you to act on the member's behalf.

Mail this completed form to: **Aetna Life Insurance Company**  
PO Box 14560  
Lexington, KY 40512-4560  
Fax Number: 1-866-667-1987

MI DT 48-045 WKAB-Generic  
GC-1499-5 (6-13) G

R-POD



0220140004

Claim Number: 9452367

Employee Name

DAVIS, ARTHUR

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

MI DT 48-045 WKAB  
GC-1499-5 (6-13)

Page 2



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Claim Number: 9452367

# aetna Reimbursement Agreement (LTD)

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company (Aetna) has contracted with my employer Dell Inc to administer the LTD plan under which I am a covered employee.

If my application for Long Term Disability ("LTD") benefits is approved, in consideration of the payment of LTD benefits without reduction on account of other benefit payments to which I or my eligible dependents may become entitled under the United States Social Security Act or from any of the other income sources described in the LTD plan, I hereby agree to reimburse Aetna, on behalf of the plan, for any and all overpayments made to me under the LTD plan or any short term disability plan provided by my employer. I understand that Aetna agrees to make payment in this manner in consideration of my agreement to promptly notify Aetna of the amounts and effective dates of any such benefits, and to promptly repay same. This reimbursement is applicable whether said amounts are paid by formal award, informal compromise, settlement, redemption agreement, or otherwise, regardless of the term used to describe such payment under applicable law. Further, I agree that any benefits due me, my beneficiaries, heirs, executors, administrators, or assigns under the LTD plan may be applied to any outstanding overpayment whether resulting from retroactive award of Social Security or any other income benefits as described in the LTD plan.



Signature of Employee/Authorized Representative

REDACTED

Social Security Number

Employee Gender ☒ Male ☐ Female

REDACTED

Date of Birth (MM/DD/YYYY):

02/14/2014

Signature Date (MM/DD/YYYY)

Mail this completed form to:  
Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: 800-354-1779  
Fax: 1-866-667-1987

MI DT 48-008 ASC WKAB-Generic  
GC-1587-5 (4-12)



0220140004



Claim Number: 9452367

# aetna® Reimbursement Agreement (LTD)

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company (Aetna) has issued to my employer, Dell Inc  
policy under which I am a covered employee.

the LTD

If my application for Long Term Disability ("LTD") benefits is approved, in consideration of the payment of LTD benefits without reduction on account of other benefit payments to which I or my eligible dependents may become entitled under the United States Social Security Act or from any of the other income sources described in the LTD policy, I hereby agree to reimburse Aetna for any and all overpayments made to me under the LTD policy or any short term disability plan provided by employer. I understand that Aetna agrees to make payment in this manner in consideration of my agreement to promptly notify Aetna of the amounts and effective dates of any such benefits, and to promptly repay same. This reimbursement is applicable whether said amounts are paid by formal award, informal compromise, settlement, redemption agreement, or otherwise, regardless of the term used to describe such payment under applicable law. Further, I agree that any benefits due me, my beneficiaries, heirs, executors, administrators or assigns under the LTD policy may be applied to any outstanding overpayment whether resulting from retroactive award of Social Security or any other income benefits as described in the LTD policy.

With respect to any group life insurance coverage provided me by Aetna and in consideration of the foregoing, I hereby assign to Aetna, as creditor beneficiary, an amount of such group life insurance equal to the amount of any overpayment which may be outstanding under the LTD policy at the time of death.

*John C. Day*

Signature of Employee/Authorized Representative

REDACTED

Social Security Number

Employee Gender ☒ Male ☐ Female

REDACTED

Date of Birth (MM/DD/YYYY):

02/14/2014

Signature Date (MM/DD/YYYY)

Mail this completed form to:

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: 800-354-1779  
Fax: 1-866-667-1987

MI DT 48-008 Insured WKAB-Generlc  
GC-1589-5 (4-12)



0220140004

Claim Number: 9452367

# Form W-4 (2014)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

**Exemption from withholding.** If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$1,000 and includes more than \$350 of unearned income (for example, interest and dividends).

**Exemptions.** An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income, tax credits, or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than \$1,000,000.

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

**Head of household.** Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners or multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

**Nonresident alien.** If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

**Future developments.** Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at [www.irs.gov/w-4](http://www.irs.gov/w-4)

## Personal Allowances Worksheet (Keep for your records.)

<p><b>A</b> Enter "1" for yourself if no one else can claim you as a dependent . . . . . <b>A</b> _____</p> <p><b>B</b> Enter "1" if:   <div style="display: inline-block; vertical-align: top;"> <ul style="list-style-type: none"> <li>• You are single and have only one job; or</li> <li>• You are married, have only one job, and your spouse does not work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul> </div> . . . . . <b>B</b> _____</p> <p><b>C</b> Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . <b>C</b> _____</p> <p><b>D</b> Enter number of dependents (other than your spouse or yourself) you will claim on your tax return . . . . . <b>D</b> _____</p> <p><b>E</b> Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) . . . . . <b>E</b> _____</p> <p><b>F</b> Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit . . . . . <b>F</b> _____          (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)</p> <p><b>G</b> Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.          • If your total income will be less than \$65,000 (\$95,000 if married), enter "2" for each eligible child; then less "1" if you have three to six eligible children or less "2" if you have seven or more eligible children.          • If your total income will be between \$65,000 and \$84,000 (\$95,000 and \$119,000 if married), enter "1" for each eligible child . . . . . <b>G</b> _____</p> <p><b>H</b> Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ► <b>H</b> _____</p>	<p>For accuracy, complete all worksheets that apply.</p> <ul style="list-style-type: none"> <li>• If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.</li> <li>• If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.</li> <li>• If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.</li> </ul>
--	---

Separate here and give Form W-4 to your employer. Keep the top part for your records.

<div style="display: flex; justify-content: space-between;"> <div> <p><b>Form W-4</b></p> <p>Department of the Treasury Internal Revenue Service</p> </div> <div> <p><b>Employee's Withholding Allowance Certificate</b></p> <p>► Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p> </div> <div> <p>OMB No. 1545-0074</p> <p style="font-size: 2em; font-weight: bold;">2014</p> </div> </div>					
1 Your first name and middle initial <b>ARTHUR</b>		Last name <b>DAVIS</b>		2 Your social security number	
Home address (number and street or rural route)				3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code				4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► <input type="checkbox"/>	
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5		6 \$	
6 Additional amount, if any, you want withheld from each paycheck					
7 I claim exemption from withholding for 2014, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here. . . . . <b>Exempt</b>					
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.					
Employee's signature (This form is not valid unless you sign it.) ► <b>Arthur C Davis</b> Date ► <b>2/14/14</b>					
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)				9 Office code (optional)	
				10 Employer identification number (EIN)	

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 102200

Form W-4 (2014)





## Fax Message

---

**To:** Scanning  
**Fax:** 8666671987  
**From:** Amor, Maribel  
**Date:** 2/18/2014 2:33 PM  
**Pages:** 1 of 3 (including this page)  
**Subject:** LTD eligibility

---

**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Claim 9452367

*Maribel Amor, MST  
Senior Disability Benefit Manager  
Aetna Life Insurance Company  
Ph: 954-693-2140  
Fax: 860-907-4494  
E-mail: AmorM@Aetna.com*

**Amor, Maribel**

---

**From:** Chad\_Fiebig@Dell.com  
**Sent:** Tuesday, February 18, 2014 2:31 PM  
**To:** Amor, Maribel  
**Subject:** RE: LTD Eligibility

Dell - Internal Use - Confidential

Yes he did contribute to LTD since 5/22/06

**From:** Amor, Maribel [mailto:AmorM@aetna.com]  
**Sent:** Tuesday, February 18, 2014 1:23 PM  
**To:** Fiebig, Chad  
**Subject:** LTD Eligibility  
**Importance:** High

RE: Arthur Davis  
Claim 9452367  
Dell Inc, ID: 900600

Hi Chad,

Please advise whether Mr. Davis has LTD eligibility, and if he does please provide me with the effective date. Thanks,  
Maribel

*Maribel Amor, MST  
Senior Disability Benefit Manager  
Aetna Life Insurance Company  
Ph: 954-693-2140  
Fax: 860-907-4494  
E-mail: AmorM@Aetna.com*

This e-mail may contain confidential or privileged information. If you think you have received this e-mail in error, please advise the sender by reply e-mail and then delete this e-mail immediately. Thank you. Aetna



## Facsimile Transmittal Sheet

To:	From:
Murfreesboro Results Physiotherapy	MARIBEL AMOR
Employer:	Date:
Dell Inc	02/17/2014
Fax Number:	CLAIM NUMBER:
615-896-6825	9452367
Phone number:	Sender's Phone Number:
615-896-6825	800-354-1779
	Sender's FAX Number:
	1-866-667-1987
Re: MR. ARTHUR DAVIS	Total No. of Pages Including Cover:
Date of Birth: REDACTED	

Urgent For Review Please Comment xx Please Reply Please Recycle

Mr. Davis is being reviewed for eligibility to receive LTD benefits. Please submit the progress notes and evaluations for the last three months of treatment. Thanks, Maribel

Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

## Disclaimer:

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you received this communication in error, please notify the sender at the phone number above.

## NOTICE TO RECIPIENT(S) OF INFORMATION:

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

The information contained in this document is CONFIDENTIAL if you have received this in error, please fax immediately to 1-866-667-1987. Thank you.

Enclosed:



Results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Feb 17 2014 07:42am

P002

Patient: **ARTHUR DAVIS**  
Acct #: 124961  
DOB: **REDACTED**  
Physician: Nicholas Cote MD  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Visit Date: **Jan 20, 2014**  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 1  
Cxl/Ns: 0

Employer: DISABILITY  
Insured:

## Plan of Care

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

### Assessment

Pt present with irritable low back/sacral pain impacting ADL's (working, sitting, standing etc.). Unable to assess joint mobility at time of eval secondary to muscle guarding. Pt would benefit from skilled PT services to address functional return to ADL's.

**Treatment Emphasis to focus on: Maximizing function related to:**

- ADL's. Work performance.

### Problems & Goals

**Problem #1 Chief Complaint: Pain: Current Severity: 8/10.**

*LTG Achieve by Feb 17, 2014.*

**Symptomatic Improvements:**

- Decreasing Pain: to 3/10.

**Problem #2 Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient.**

- Score 38

*LTG Achieve by Feb 17, 2014.*

**Questionnaire Improvements: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Follow Up: Patient:**

- Score 50

**Problem #3 Client Knowledge/Awareness of: Home Exercise Program: Lacks appropriate program.**

*STG Achieve by Feb 03, 2014.*

**Client Education:**

- Independent Home Exercise/Self Care Program.

**Problem #4 Range of Motion: Spine: Pre-Treatment: Active Lumbosacral.**

- |                                 |     |
|---------------------------------|-----|
| • Extension                     | 50% |
| • Flexion(increased pain)       | 75% |
| • Side Bending Left             | 75% |
| • Side Bending Right(most pain) | 75% |

*LTG Achieve by Feb 17, 2014.*

**Range of Motion Improvements to: Active Lumbosacral:**

- Gross Assessment WNL

<b>Problem #5 Palpation: Lumbosacral Region: Musculature,</b>	<b>Left</b>	<b>Right</b>
<b>Posterior: Guarding.</b>		

- |                      |        |        |
|----------------------|--------|--------|
| • Gluteus Maximus    | Severe | Severe |
| • Piriformis         | Severe | Severe |
| • Quadratus Lumborum | Severe | Severe |

*LTG Achieve by Feb 17, 2014. to improve sitting tolerance.*

**Palpable Improvements:**

- Guarding Decreasing to: Moderate Levels.

**Problem #6 Observations: Pt able to sit <1 minutes before position changed required secondary to pain.**

*LTG Achieve by Feb 17, 2014. to improve sitting tolerance.*

Document ID: 0070090B.002  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2

Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Jan 20, 2014

**Functional Test Improvements:**

- Pt to sit  $\geq 10$  minutes before needing position change.

**Plan****Amount, Frequency and Duration:**

- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 3 visits a week with an expected duration of 6 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

**Therapeutic Contents:**

- Client Education. Gait Training. Home Exercise Program. Joint Mobilization Techniques. Manual Therapy Techniques. Modalities: As Needed. Therapeutic Activities. Therapeutic Exercise.
- Additional:
  - Brace/Tape/Splint: Tape. Trigger Point Dry Needling

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886), DPT

Signed on Jan 20, 2014 12:35:10

**Please sign and return**

I have reviewed this Plan of Care and certify that the skilled therapy services identified are required to meet the patient's need.  
Comments and/or revisions to this Plan of Care are noted below.

**Comments/Revisions**

Nicholas Cote MD

Date





Results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote MD  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
PSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Feb 17 2014 07:43am

P004

Visit Date: Jan 21, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 2  
Cxl/Ns: 0

Employer: DISABILITY  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 5/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 38

## Objective Examination

### Observations:

- Pt able to sit <1 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:**

### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

Left

Severe  
Severe  
Severe

Right

Severe  
Severe  
Severe

**Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:**

- Extension 75%
- Flexion(increased pain) 75%
- Side Bending Left 75%
- Side Bending Right(most pain) 75%

**Range of Motion: Spine: Post-Treatment: Active Lumbosacral:**

- Extension 75%
- Flexion 100%

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
Electrical Stimulation (unattended)	97014	1	n/a
Manual Therapy Techniques	97140	2	22
Therapeutic Procedure	97110	2	30

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1

Time Elapsed: 30 Minutes, Description: see exercise log, Charge As:  
Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1(This visit)

Did Not Perform: This visit

### Manual Interventions: Vertebral Joint Segments:

Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Jan 21, 2014

**• Lumbosacral Spine**

Time Elapsed: 12 Minutes, Grade: 2, Body Position: prone pillow under hips, Additional Detail: L 1-5 bilat, Pressure: Oscillatory, Technique 1: Unilateral P-A, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Did Not Perform: This visit

**• Vertebral Jt Seg Mobilization 1(This visit)****Manual Interventions: Lower Quarter Soft Tissue:****• Thoracolumbar PVM**

Time Elapsed: 10 Minutes, Tx Depth: Superficial, Technique: Strumming, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Modalities:****• Electric Stim, Unattended**

Time Elapsed: 12 Minutes, Location: lumbar, Performed With: cryotherapy, Mode: Continuous, Type: Interferential, Clinical Use: Post Activity, Charge As: E-Stim, Unattended, Billing Code: 97014.

**Timed Code Total Time:****• 52 Minutes****Assessment****The client tolerated today's treatment/therapeutic activity with mild complaints of pain and difficulty.****Signs/Symptoms:****• Pain: Decreased.****Treatment Emphasis to focus on:****• Maximizing function related to: ADL's.****Plan****Daily Plan:****• Continue w/ Current Rehabilitation Program.**

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT

Signed on Jan 21, 2014 11:13:36



Results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote MD  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Feb 17 2014 07:43am

P006

Visit Date: Jan 23, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 3  
Cxl/Ns: 0

Employer: DISABILITY  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

Low back is "burning today".

### Chief Complaint:

- Pain: Current Severity: 8/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:

- Score 38

## Objective Examination

### Observations:

- Pt able to sit <1 minutes before position changed required secondary to pain.

Palpation: Lumbosacral Region: Musculature, Posterior:	Left	Right
<b>Guarding:</b>		
• Gluteus Maximus	Severe	Severe
• Piriformis	Severe	Severe
• Quadratus Lumborum	Severe	Severe

### Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

- |                                 |     |
|---------------------------------|-----|
| • Extension                     | 75% |
| • Flexion(increased pain)       | 75% |
| • Side Bending Left             | 75% |
| • Side Bending Right(most pain) | 75% |

### Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

- |             |      |
|-------------|------|
| • Extension | 75%  |
| • Flexion   | 100% |

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Manual Therapy Techniques	97140	2	17
• Therapeutic Procedure	97110	2	30

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1

Time Elapsed: 30 Minutes, Description: see exercise log, Charge As:  
Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1(This visit)

Did Not Perform: This visit

### Manual Interventions: Vertebral Joint Segments:

- Lumbosacral Spine(This visit)

Did Not Perform: This visit

Document ID: 0070090B.004  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2



Patient: ARTHUR DAVIS  
Acet #: 124961

Visit Date: Jan 23, 2014

- Vertebral Jt Seg Mobilization 1

Time Elapsed: 9 Minutes, Grade: 1, Body Position: supine,  
Additional Detail: bilat, Pressure: Oscillatory, Technique 1: light  
long axis lumbar distraction, Charge As: Manual Therapy  
Techniques, Billing Code: 97140.

- Vertebral Jt Seg Mobilization 2

Time Elapsed: 8 Minutes, Grade: 2, Body Position: side lying  
lumbar rotation, Pressure: Oscillatory, Technique 1: rotation, Charge  
As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

Did Not Perform: This visit

**Modalities:**

- Electric Stim, Unattended(This visit)

Did Not Perform: This visit

**Timed Code Total Time:**

- 47 Minutes

**Assessment**

Pt refused Stim this session secondary to time restraints. Pt with improved ROM and decreased C/O pain after manual.

**Treatment Emphasis to focus on:**

- Maximizing function related to: ADL's.

**Plan****Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Jan 23, 2014 10:26:19



Results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote MD  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Feb 17 2014 07:44am

P008

Visit Date: Jan 21, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 2  
Cxl/Ns: 0

Employer: DISABILITY  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 5/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 38

## Objective Examination

### Observations:

- Pt able to sit <1 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:** Left Right

### Guarding:

- |                      |        |        |
|----------------------|--------|--------|
| • Gluteus Maximus    | Severe | Severe |
| • Piriformis         | Severe | Severe |
| • Quadratus Lumborum | Severe | Severe |

### Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

- |                                 |     |
|---------------------------------|-----|
| • Extension                     | 75% |
| • Flexion(increased pain)       | 75% |
| • Side Bending Left             | 75% |
| • Side Bending Right(most pain) | 75% |

### Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

- |             |      |
|-------------|------|
| • Extension | 75%  |
| • Flexion   | 100% |

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Electrical Stimulation (unattended)	97014	1	n/a
• Manual Therapy Techniques	97140	2	22
• Therapeutic Procedure	97110	2	30

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1

Time Elapsed: 30 Minutes, Description: see exercise log, Charge As:  
Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1(This visit) Did Not Perform: This visit

### Manual Interventions: Vertebral Joint Segments:

Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Jan 21, 2014

## • Lumbosacral Spine

Time Elapsed: 12 Minutes, Grade: 2, Body Position: prone pillow under hips, Additional Detail: L 1-5 bilat, Pressure: Oscillatory, Technique 1: Unilateral P-A, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Did Not Perform: This visit

## • Vertebral Jt Seg Mobilization I(This visit)

**Manual Interventions: Lower Quarter Soft Tissue:**

## • Thoracolumbar PVM

Time Elapsed: 10 Minutes, Tx Depth: Superficial, Technique: Strumming, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Modalities:**

## • Electric Stim, Unattended

Time Elapsed: 12 Minutes, Location: lumbar, Performed With: cryotherapy, Mode: Continuous, Type: Interferential, Clinical Use: Post Activity, Charge As: E-Stim, Unattended, Billing Code: 97014.

**Timed Code Total Time:**

## • 52 Minutes

**Assessment**

The client tolerated today's treatment/therapeutic activity with mild complaints of pain and difficulty.

**Signs/Symptoms:**

## • Pain: Decreased.

**Treatment Emphasis to focus on:**

## • Maximizing function related to: ADL's.

**Plan****Daily Plan:**

## • Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT

Signed on Jan 21, 2014 11:13:36



Results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Feb 17 2014 07:44am

P010

Visit Date: Jan 27, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 4  
Cxl/Ns: 0

Employer: DELL  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 8/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 38

## Objective Examination

### Observations:

- Pt able to sit <1 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:** Left Right

### Guarding:

- |                      |          |          |
|----------------------|----------|----------|
| • Gluteus Maximus    | Moderate | Moderate |
| • Piriformis         | Moderate | Moderate |
| • Quadratus Lumborum | Moderate | Moderate |

**Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:**

- |                           |      |
|---------------------------|------|
| • Extension               | 100% |
| • Flexion(increased pain) | 100% |
| • Side Bending Left       | 100% |
| • Side Bending Right      | 100% |

**Range of Motion: Spine: Post-Treatment: Active Lumbosacral:**

- |             |      |
|-------------|------|
| • Extension | 100% |
| • Flexion   | 100% |

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Manual Therapy Techniques	97140	2	16
• Therapeutic Activities	97530	1	10
• Therapeutic Procedure	97110	2	30

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1

Time Elapsed: 30 Minutes, Description: see exercise log, Charge As:  
Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1

Time Elapsed: 10 Minutes, Description: see exercise log, Charge As:  
Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

- Lumbosacral Spine(This visit)

Did Not Perform: This visit

Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Jan 27, 2014

- Vertebral Jt Seg Mobilization 1

Time Elapsed: 8 Minutes, Grade: 3-, Body Position: supine,  
Additional Detail: bilat, Pressure: Oscillatory, Technique 1: light  
long axis lumbar distraction, Charge As: Manual Therapy  
Techniques, Billing Code: 97140.

- Vertebral Jt Seg Mobilization 2

Time Elapsed: 8 Minutes, Grade: -3, Body Position: side lying  
lumbar rotation, Pressure: Oscillatory, Technique 1: rotation, Charge  
As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

Did Not Perform: This visit

**Modalities:**

- Electric Stim, Unattended(This visit)

Did Not Perform: This visit

**Timed Code Total Time:**

- 56 Minutes

**Assessment**

Pt able to tolerate increased grade mobilization this session and improved ROM. Pt with continued c/o decreased sitting tolerance.

**Plan****Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Jan 27, 2014 10:38:44





Results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

**Patient:** ARTHUR DAVIS  
**Acct #:** 124961  
**DOB:** REDACTED  
**Physician:** Nicholas Cote MD  
**Phys Fax:** (615) 867-7945  
**Physician:** Not Specified  
**Clinician:** Lakota C. Hillis  
**FSC:** Commercial Insurance  
**Case Mgr:**  
**Payor:** AETNA  
**Pol/Claim#:**

Feb 17 2014 07:45am

P012

**Visit Date:** Jan 23, 2014  
**Phys Phone:** (615) 867-8010  
**SSN:** XXX-XX-XXXX  
**Inj. Date:** Jan 20, 2014  
**Surg. Date:**  
**Visits:** 3  
**Cxl/Ns:** 0

**Employer:** DISABILITY  
**Insured:**

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

### Subjective Examination

Low back is "burning today".

**Chief Complaint:**

- Pain: Current Severity: 8/10.

**Client Knowledge/Awareness of:**

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 38

### Objective Examination

**Observations:**

- Pt able to sit <1 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:** Left Right

**Guarding:**

- |                      |        |        |
|----------------------|--------|--------|
| • Gluteus Maximus    | Severe | Severe |
| • Piriformis         | Severe | Severe |
| • Quadratus Lumborum | Severe | Severe |

**Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:**

- |                                 |     |
|---------------------------------|-----|
| • Extension                     | 75% |
| • Flexion(increased pain)       | 75% |
| • Side Bending Left             | 75% |
| • Side Bending Right(most pain) | 75% |

**Range of Motion: Spine: Post-Treatment: Active Lumbosacral:**

- |             |      |
|-------------|------|
| • Extension | 75%  |
| • Flexion   | 100% |

### Treatments

**Documented Procedural Code Summary:**

Description	Code	Units	Minutes
• Manual Therapy Techniques	97140	2	17
• Therapeutic Procedure	97110	2	30

**Exercise Activities: Machines/Wts.(L. Quarter):**

- Machines/Free Weights 1 Time Elapsed: 30 Minutes, Description: see exercise log, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):**

- Closed Kinetic Chain 1(This visit) Did Not Perform: This visit

**Manual Interventions: Vertebral Joint Segments:**

- Lumbosacral Spine(This visit) Did Not Perform: This visit



Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Jan 23, 2014

- Vertebral Jt Seg Mobilization 1

Time Elapsed: 9 Minutes, Grade: 1, Body Position: supine,  
Additional Detail: bilat, Pressure: Oscillatory, Technique 1: light  
long axis lumbar distraction, Charge As: Manual Therapy  
Techniques, Billing Code: 97140.

- Vertebral Jt Seg Mobilization 2

Time Elapsed: 8 Minutes, Grade: 2, Body Position: side lying  
lumbar rotation, Pressure: Oscillatory, Technique 1: rotation, Charge  
As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

**Modalities:**

- Electric Stim, Unattended(This visit)

**Timed Code Total Time:**

- 47 Minutes

Did Not Perform: This visit

Did Not Perform: This visit

**Assessment**

Pt refused Stim this session secondary to time restraints. Pt with improved ROM and decreased C/O pain after manual.

**Treatment Emphasis to focus on:**

- Maximizing function related to: ADL's.

**Plan****Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Jan 23, 2014 10:26:19



results PHYSIOTHERAPY  
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Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Feb 17 2014 07:45am

P014

Visit Date: Jan 28, 2014  
Phys Phone: (615) 867-8010  
SSN: XXXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 5  
Cxl/Ns: 0

Employer: DALL  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 8/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 38

## Objective Examination

### Observations:

- Pt able to sit <1 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:**

### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

Left

Moderate  
Moderate  
Mild

Right

Moderate  
Moderate  
Mild

**Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:**

- Extension 100%
- Flexion(increased pain) 100%
- Side Bending Left 100%
- Side Bending Right 100%

**Range of Motion: Spine: Post-Treatment: Active Lumbosacral:**

- Extension 100%
- Flexion 100%

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
Manual Therapy Techniques	97140	1	12
Therapeutic Activities	97530	2	18
Therapeutic Procedure	97110	2	18

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1

Time Elapsed: 18 Minutes, Description: see exercise log, Charge As:  
Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1

Time Elapsed: 18 Minutes, Description: see exercise log, Charge As:  
Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Jan 28, 2014

---

- Lumbosacral Spine

Time Elapsed: 12 Minutes, Grade: 3+, Body Position: prone pillow under hips, Additional Detail: L 1-5 bilat, Pressure: Oscillatory, Technique 1: Unilateral P-A, Charge As: Manual Therapy Techniques, Billing Code: 97140.

- Vertebral Jt Seg Mobilization 1(This visit)
- Vertebral Jt Seg Mobilization 2(This visit)

Did Not Perform: This visit

Did Not Perform: This visit

**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

Did Not Perform: This visit

**Modalities:**

- Electric Stim, Unattended(This visit)

Did Not Perform: This visit

**Timed Code Total Time:**

- 48 Minutes

**Assessment**

Pt with continued high subjective C/O pain with improved ROM and able to tolerate higher grades of mobilization this session. Will continue to progress as tolerated.

**Plan****Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

---

Lakota C. Hillis, PT(TN Lic: 8886), DPT  
Signed on Jan 28, 2014 11:26:52



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37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

**Patient:** ARTHUR DAVIS  
**Acct #:** 124961  
**DOB:** REDACTED  
**Physician:** Nicholas Cote DO  
**Phys Fax:** (615) 867-7945  
**Physician:** Not Specified  
**Clinician:** Lakota C. Hillis  
**FSC:** Commercial Insurance  
**Case Mgr:**  
**Payor:** AETNA  
**Pol/Claim#:**

Feb 17 2014 07:46am P016

**Visit Date:** Jan 27, 2014  
**Phys Phone:** (615) 867-8010  
**SSN:** XXX-XX-XXXX  
**Inj. Date:** Jan 20, 2014  
**Surg. Date:**  
**Visits:** 4  
**Cxl/Ns:** 0

**Employer:** DELL  
**Insured:**

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 8/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 38

## Objective Examination

### Observations:

- Pt able to sit <1 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:**

### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

**Left**

Moderate  
Moderate  
Moderate

**Right**

Moderate  
Moderate  
Moderate

**Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:**

- Extension 100%
- Flexion (increased pain) 100%
- Side Bending Left 100%
- Side Bending Right 100%

**Range of Motion: Spine: Post-Treatment: Active Lumbosacral:**

- Extension 100%
- Flexion 100%

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Manual Therapy Techniques	97140	2	16
• Therapeutic Activities	97530	1	10
• Therapeutic Procedure	97110	2	30

### Exercise Activities: Machines/Wts. (L. Quarter):

- Machines/Free Weights 1

Time Elapsed: 30 Minutes, Description: see exercise log, Charge As:  
Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1

Time Elapsed: 10 Minutes, Description: see exercise log, Charge As:  
Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

- Lumbosacral Spine (This visit)

Did Not Perform: This visit



results PHYSIOTHERAPY Fax: 615-896-6825  
Patient: ARTHUR DAVIS  
Accl #: 124961

Feb 17 2014 07:46am P017

Visit Date: Jan 27, 2014

- Vertebral Jt Seg Mobilization 1

Time Elapsed: 8 Minutes, Grade: 3-, Body Position: supine,  
Additional Detail: bilat, Pressure: Oscillatory, Technique 1: light  
long axis lumbar distraction, Charge As: Manual Therapy  
Techniques, Billing Code: 97140.

- Vertebral Jt Seg Mobilization 2

Time Elapsed: 8 Minutes, Grade: +3, Body Position: side lying  
lumbar rotation, Pressure: Oscillatory, Technique 1: rotation, Charge  
As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

Did Not Perform: This visit

**Modalities:**

- Electric Stim, Unattended(This visit)

Did Not Perform: This visit

**Timed Code Total Time:**

- 56 Minutes

## Assessment

Pt able to tolerate increased grade mobilization this session and improved ROM. Pt with continued c/o decreased sitting tolerance.

## Plan

**Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886), DPT  
Signed on Jan 27, 2014 10:38:44



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results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
PSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Feb 17 2014 07:46am

P018

Visit Date: Jan 30, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 6  
Cxl/Ns: 0

Employer: DELL  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 6/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 38

## Objective Examination

### Observations:

- Pt able to sit 5 minutes before position changed required secondary to pain. Body Mechanics: Pt sat for 5 minutes on stationary bike with no standing breaks.

**Palpation: Lumbosacral Region: Musculature, Posterior:**

**Left**

**Right**

### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

Mild  
Mild  
Mild

Mild  
Mild  
Mild

**Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:**

- Extension 100%
- Flexion(increased pain) 100%
- Side Bending Left 100%
- Side Bending Right 100%

**Range of Motion: Spine: Post-Treatment: Active Lumbosacral:**

- Extension 100%
- Flexion 100%

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Electrical Stimulation (unattended)	97014	1	n/a
• Manual Therapy Techniques	97140	1	12
• Therapeutic Activities	97530	2	18
• Therapeutic Procedure	97110	2	18

**Exercise Activities: Machines/Wts.(L. Quarter):**

- Machines/Free Weights 1

Time Elapsed: 18 Minutes, Description: see exercise log, Charge As:  
Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):**

- Closed Kinetic Chain 1

Time Elapsed: 18 Minutes, Description: see exercise log, Charge As:  
Therapeutic Activities, Billing Code: 97530.

**Manual Interventions: Vertebral Joint Segments:**

Document ID: 0070090B.007  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2



Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Jan 30, 2014

- Lumbosacral Spine

- Vertebral Jt Seg Mobilization 1(This visit)
- Vertebral Jt Seg Mobilization 2(This visit)

**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

**Modalities:**

- Electric Stim, Unattended

Time Elapsed: 12 Minutes, Grade: 3+, Body Position: prone pillow under hips, Additional Detail: L 1-5 bilat, Pressure: Oscillatory, Technique 1: Unilateral P-A, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Did Not Perform: This visit

Did Not Perform: This visit

Did Not Perform: This visit

Time Elapsed: 12 Minutes, Location: lumbar, Performed With: cryotherapy, Mode: Continuous, Type: Interferential, Clinical Use: Post Activity, Charge As: E-Stim, Unattended, Billing Code: 97014.

**Timed Code Total Time:**

- 48 Minutes

**Assessment**

Pt progressing well towards goals with increased sitting time tolerance. Will continue to progress as tolerated.

**Plan****Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Jan 30, 2014 13:04:47





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520 Highland Terrace, Suite A  
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37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Feb 17 2014 07:47am

P020

Visit Date: Jan 28, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 5  
Cxl/Ns: 0

Employer: DELTA  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 8/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient: Score 38

## Objective Examination

### Observations:

- Pt able to sit <1 minutes before position changed required secondary to pain.

### Palpation: Lumbosacral Region: Musculature, Posterior:

#### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

Left

Moderate  
Moderate  
Mild

Right

Moderate  
Moderate  
Mild

### Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

- Extension 100%
- Flexion(increased pain) 100%
- Side Bending Left 100%
- Side Bending Right 100%

### Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

- Extension 100%
- Flexion 100%

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Manual Therapy Techniques	97140	1	12
• Therapeutic Activities	97530	2	18
• Therapeutic Procedure	97110	2	18

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1

Time Elapsed: 18 Minutes, Description: see exercise log, Charge As: Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1

Time Elapsed: 18 Minutes, Description: see exercise log, Charge As: Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

Document ID: 0070090B.006  
Lakota C. Hillis, PT(TN Lic: 8886), DPT

Status: Signed off (secure electronic signature)

Page 1 of 2

Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Jan 28, 2014

**• Lumbosacral Spine**

- Vertebral Jt Seg Mobilization 1(This visit)
- Vertebral Jt Seg Mobilization 2(This visit)

**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

**Modalities:**

- Electric Stim, Unattended(This visit)

**Timed Code Total Time:**

- 48 Minutes

Time Elapsed: 12 Minutes, Grade: 3+, Body Position: prone pillow under hips, Additional Detail: L 1-5 bilat, Pressure: Oscillatory, Technique 1: Unilateral P-A, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Did Not Perform: This visit

Did Not Perform: This visit

Did Not Perform: This visit

Did Not Perform: This visit

**Assessment**

Pt with continued high subjective C/O pain with improved ROM and able to tolerate higher grades of mobilization this session. Will continue to progress as tolerated.

**Plan****Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Jan 28, 2014 11:26:52



results PHYSIOTHERAPY  
520 Highland Terrace, Suite A  
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Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Feb 17 2014 07:47am

P022

Visit Date: Jan 30, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 6  
Cxl/Ns: 0

Employer: DELI  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 6/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO); Physical Functional Status Measure: Intake: Patient:**

- Score 38

## Objective Examination

### Observations:

- Pt able to sit 5 minutes before position changed required secondary to pain. Body Mechanics: Pt sat for 5 minutes on stationary bike with no standing breaks.

### Palpation: Lumbosacral Region: Musculature, Posterior:

#### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

Left

Mild  
Mild  
Mild

Right

Mild  
Mild  
Mild

### Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

- Extension 100%
- Flexion(increased pain) 100%
- Side Bending Left 100%
- Side Bending Right 100%

### Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

- Extension 100%
- Flexion 100%

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Electrical Stimulation (unattended)	97014	1	n/a
• Manual Therapy Techniques	97140	1	12
• Therapeutic Activities	97530	2	18
• Therapeutic Procedure	97110	2	18

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1

Time Elapsed: 18 Minutes, Description: see exercise log, Charge As: Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1

Time Elapsed: 18 Minutes, Description: see exercise log, Charge As: Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

Document ID: 0070090B.007  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2

Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Jan 30, 2014

**• Lumbosacral Spine**

Time Elapsed: 12 Minutes, Grade: 3+, Body Position: prone pillow under hips, Additional Detail: L 1-5 bilat, Pressure: Oscillatory, Technique 1: Unilateral P-A, Charge As: Manual Therapy Techniques, Billing Code: 97140.

- Vertebral Jt Seg Mobilization 1(This visit)
- Vertebral Jt Seg Mobilization 2(This visit)

Did Not Perform: This visit

Did Not Perform: This visit

**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

Did Not Perform: This visit

**Modalities:**

- Electric Stim, Unattended

Time Elapsed: 12 Minutes, Location: lumbar, Performed With: cryotherapy, Mode: Continuous, Type: Interferential, Clinical Use: Post Activity, Charge As: E-Stim, Unattended, Billing Code: 97014.

**Timed Code Total Time:**

- 48 Minutes

**Assessment**

Pt progressing well towards goals with increased sitting time tolerance. Will continue to progress as tolerated.

**Plan****Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Jan 30, 2014 13:04:47



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Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Feb 17 2014 07:48am

P024

Visit Date: Feb 06, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 7  
Cxl/Ns: 0

Employer: DELL  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 6/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 38

## Objective Examination

### Observations:

- Pt able to sit 8 minutes before position changed required secondary to pain. Assistive Devices: Pt presents with sling on right shoulder. He states he is S/Lp Rotator cuff repair. Pt states he is being seen at another facility for shoulder rehab.

**Palpation: Lumbosacral Region: Musculature, Posterior:**

**Left**

**Right**

### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

Mild  
Mild  
Mild

Mild  
Mild  
Mild

**Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:**

- Extension 100%
- Flexion(increased pain) 100%
- Side Bending Left 100%
- Side Bending Right 100%

**Range of Motion: Spine: Post-Treatment: Active Lumbosacral:**

- Extension 100%
- Flexion 100%

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
Manual Therapy Techniques	97140	1	12
Strapping - Thorax	29200	1	n/a
Therapeutic Activities	97530	2	20
Therapeutic Procedure	97110	2	20

**Exercise Activities: Machines/Wts.(L. Quarter):**

- Machines/Free Weights 1

Time Elapsed: 20 Minutes, Description: see exercise log, Charge As:  
Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):**

- Closed Kinetic Chain 1

Time Elapsed: 20 Minutes, Description: see exercise log, Charge As:  
Therapeutic Activities, Billing Code: 97530.

**Manual Interventions: Vertebral Joint Segments:**

Document ID: 0070090B.008  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2



results PHYSIOTHERAPY  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payer: AETNA  
Pol/Claim#:

Feb 17 2014 07:48am

P025

Visit Date: Feb 06, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 7  
Cxl/Ns: 0

Employer: DELL  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 6/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 38

## Objective Examination

### Observations:

- Pt able to sit 8 minutes before position changed required secondary to pain. Assistive Devices: Pt presents with sling on right shoulder. He states he is S/Lp Rotator cuff repair. Pt states he is being seen at another facility for shoulder rehab.

**Palpation: Lumbosacral Region: Musculature, Posterior:**

Left

Right

### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

Mild  
Mild  
Mild

Mild  
Mild  
Mild

**Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:**

- Extension 100%
- Flexion(increased pain) 100%
- Side Bending Left 100%
- Side Bending Right 100%

**Range of Motion: Spine: Post-Treatment: Active Lumbosacral:**

- Extension 100%
- Flexion 100%

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
Manual Therapy Techniques	97140	1	12
Strapping - Thorax	29200	1	n/a
Therapeutic Activities	97530	2	20
Therapeutic Procedure	97110	2	20

**Exercise Activities: Machines/Wts.(L. Quarter):**

- Machines/Free Weights 1

Time Elapsed: 20 Minutes, Description: see exercise log, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):**

- Closed Kinetic Chain 1

Time Elapsed: 20 Minutes, Description: see exercise log, Charge As: Therapeutic Activities, Billing Code: 97530.

**Manual Interventions: Vertebral Joint Segments:**

Document ID: 0070090B.008  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2

Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Feb 06, 2014

## • Lumbosacral Spine

- Vertebral Jt Seg Mobilization 1(This visit)
- Vertebral Jt Seg Mobilization 2(This visit)

**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

**Manual Interventions: Taping To Stabilize/Align:**

- Strapping Activity 1

**Modalities:**

- Electric Stim, Unattended(This visit)

**Timed Code Total Time:**

- 52 Minutes

Time Elapsed: 12 Minutes, Grade: 3+, Body Position: prone, pillow under hips, Additional Detail: L 1-5 bilat, Pressure: Oscillatory, Technique 1: Unilateral P-A, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Did Not Perform: This visit

Did Not Perform: This visit

Did Not Perform: This visit

Time Elapsed: 5 Minutes, Technique: With tech assistance for holding shirt, Clinical Use: Decrease Pain, Instruction: 1:1 taping on thoraco-lumbar, Placement: Low Back, Charge As: Strapping - Thorax, Billing Code: 29200.

Did Not Perform: This visit

**Assessment**

There-ex modified this session secondary to pt post op status. Pt kept in sling for all there-ex. Pt with continued c/o pain but improved ROM, decreased muscle guarding and demonstrates improved sitting tolerance.

**Plan****Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Feb 06, 2014 14:11:03



results PHYSIOTHERAPY  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825  
Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Feb 17 2014 07:49am

P027

Visit Date: Feb 07, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 8  
Cxl/Ns: 0

Employer: DELL  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 6/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 38

## Objective Examination

### Observations:

- Pt able to sit 8 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:**

### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

Left

Mild  
Mild  
Mild

Right

Mild  
Mild  
Mild

**Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:**

- Extension 100%
- Flexion (increased pain) 100%
- Side Bending Left 100%
- Side Bending Right 100%

**Range of Motion: Spine: Post-Treatment: Active Lumbosacral:**

- Extension 100%
- Flexion 100%

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
Manual Therapy Techniques	97140	1	8
Therapeutic Activities	97530	2	20
Therapeutic Procedure	97110	2	20

### Exercise Activities: Machines/Wts. (L. Quarter):

- Machines/Free Weights 1

Time Elapsed: 20 Minutes, Description: see exercise log, Charge As: Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1

Time Elapsed: 20 Minutes, Description: see exercise log, Charge As: Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

- Lumbosacral Spine (This visit)
- Vertebral Jt Seg Mobilization 1 (This visit)

Did Not Perform: This visit  
Did Not Perform: This visit





- Vertebral Jt Seg Mobilization 2

Time Elapsed: 8 Minutes, Grade: 3, Body Position: left side lying  
lumbar rotation, Pressure: Oscillatory, Technique 1: rotation, Charge  
As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

Did Not Perform: This visit

**Manual Interventions: Taping To Stabilize/Align:**

- Strapping Activity 1(This visit)

Did Not Perform: This visit

**Modalities:**

- Electric Stim, Unattended(This visit)

Did Not Perform: This visit

**Timed Code Total Time:**

- 48 Minutes

## Assessment

Pt progressing well towards goals objectively with improved sitting time and improved there-ex tolerance. Pt with continued C/O pain with sitting but is able to sit longer before position change. Will continue to progress as tolerated. Pt kept in shoulder sling for all there-ex. Pt with no c/o pain after manual.

## Plan

**Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated,

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Feb 07, 2014 13:49:06



Results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: **ARTHUR DAVIS**  
Acct #: 124961  
DOB: **REDACTED**  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Feb 17 2014 07:49am

P029

Visit Date: **Feb 07, 2014**  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 8  
Cxl/Ns: 0

Employer: DELL  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 6/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

### Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:

- Score 38

## Objective Examination

### Observations:

- Pt able to sit 8 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:** Left Right

### Guarding:

- |                      |      |      |
|----------------------|------|------|
| • Gluteus Maximus    | Mild | Mild |
| • Piriformis         | Mild | Mild |
| • Quadratus Lumborum | Mild | Mild |

### Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

- |                           |      |
|---------------------------|------|
| • Extension               | 100% |
| • Flexion(increased pain) | 100% |
| • Side Bending Left       | 100% |
| • Side Bending Right      | 100% |

### Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

- |             |      |
|-------------|------|
| • Extension | 100% |
| • Flexion   | 100% |

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Manual Therapy Techniques	97140	1	8
• Therapeutic Activities	97530	2	20
• Therapeutic Procedure	97110	2	20

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1 Time Elapsed: 20 Minutes, Description: see exercise log, Charge As: Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1 Time Elapsed: 20 Minutes, Description: see exercise log, Charge As: Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

- |   |                             |
|---|-----------------------------|
| • Lumbosacral Spine(This visit)               | Did Not Perform: This visit |
| • Vertebral Jt Seg Mobilization 1(This visit) | Did Not Perform: This visit |

Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Feb 07, 2014

- Vertebral Jt Seg Mobilization 2

Time Elapsed: 8 Minutes, Grade: 3, Body Position: left side lying  
lumbar rotation, Pressure: Oscillatory, Technique 1: rotation, Charge  
As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

Did Not Perform: This visit

**Manual Interventions: Taping To Stabilize/Align:**

- Strapping Activity 1(This visit)

Did Not Perform: This visit

**Modalities:**

- Electric Stim, Unattended(This visit)

Did Not Perform: This visit

**Timed Code Total Time:**

- 48 Minutes

## Assessment

Pt progressing well towards goals objectively with improved sitting time and improved there-ex tolerance. Pt with continued C/O pain with sitting but is able to sit longer before position change. Will continue to progress as tolerated. Pt kept in shoulder sling for all there-ex. Pt with no c/o pain after manual.

## Plan

**Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Feb 07, 2014 13:49:06



Results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Feb 17 2014 07:50am

P031

Patient: **ARTHUR DAVIS**  
Acct #: 124961  
DOB: **REDACTED**  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Visit Date: **Feb 10, 2014**  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 9  
Cxl/Ns: 0

Employer: DELL  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain; Current Severity: 6/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

### Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:

- Score 38

## Objective Examination

### Observations:

- Pt able to sit 8 minutes before position changed required secondary to pain.

### Palpation: Lumbosacral Region: Musculature, Posterior:

Left

Right

### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

Mild  
Mild  
Mild

Mild  
Mild  
Mild

### Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

- Extension 100%
- Flexion(increased pain) 100%
- Side Bending Left 100%
- Side Bending Right 100%

### Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

- Extension 100%
- Flexion 100%

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Manual Therapy Techniques	97140	1	8
• Therapeutic Activities	97530	2	16
• Therapeutic Procedure	97110	2	20

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1

Time Elapsed: 20 Minutes, Description: see exercise log, Charge As:  
Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1

Time Elapsed: 16 Minutes, Description: see exercise log, Charge As:  
Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

- Lumbosacral Spine(This visit)
- Vertebral Jt Seg Mobilization 1(This visit)

Did Not Perform: This visit  
Did Not Perform: This visit

Document ID: 0070090B.010  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2





Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Feb 10, 2014

- Vertebral Jt Seg Mobilization 2

Time Elapsed: 8 Minutes, Grade: 3, Body Position: left side lying  
lumbar rotation, Pressure: Oscillatory, Technique 1: rotation, Charge  
As: Manual Therapy Techniques, Billing Code: 97140.**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

Did Not Perform: This visit

**Manual Interventions: Taping To Stabilize/Align:**

- Strapping Activity 1(This visit)

Did Not Perform: This visit

**Modalities:**

- Electric Stim, Unattended(This visit)

Did Not Perform: This visit

**Timed Code Total Time:**

- 44 Minutes

## Assessment

Pt re-educated on HEP and advised to not perform there-ex which have him lay on his surgical side. Pt verbalized understanding. Pt with improved endurance and ROM overall with continued high subjective c/o pain.

## Plan

**Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Feb 10, 2014 12:15:22



results PHYSIOTHERAPY  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Feb 17 2014 07:51am

P035

Visit Date: Feb 10, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 9  
Cxl/Ns: 0

Employer: DELL  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 6/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

### Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:

- Score 38

## Objective Examination

### Observations:

- Pt able to sit 8 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:** Left Right

### Guarding:

- |                      |      |      |
|----------------------|------|------|
| • Gluteus Maximus    | Mild | Mild |
| • Piriformis         | Mild | Mild |
| • Quadratus Lumborum | Mild | Mild |

### Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

- |                           |      |
|---------------------------|------|
| • Extension               | 100% |
| • Flexion(increased pain) | 100% |
| • Side Bending Left       | 100% |
| • Side Bending Right      | 100% |

### Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

- |             |      |
|-------------|------|
| • Extension | 100% |
| • Flexion   | 100% |

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Manual Therapy Techniques	97140	1	8
• Therapeutic Activities	97530	2	16
• Therapeutic Procedure	97110	2	20

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1

Time Elapsed: 20 Minutes, Description: see exercise log, Charge As:  
Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1

Time Elapsed: 16 Minutes, Description: see exercise log, Charge As:  
Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

- Lumbosacral Spine(This visit)
- Vertebral Jt Seg Mobilization 1(This visit)

Did Not Perform: This visit  
Did Not Perform: This visit

Document ID: 0070090B.010  
Lakota C. Hillis,PT(TN Lic: 8886),DPT

Status: Signed off (secure electronic signature)

Page 1 of 2





- Vertebral Jt Seg Mobilization 2

Time Elapsed: 8 Minutes, Grade: 3, Body Position: left side lying  
lumbar rotation, Pressure: Oscillatory, Technique 1: rotation, Charge  
As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

Did Not Perform: This visit

**Manual Interventions: Taping To Stabilize/Align:**

- Strapping Activity 1(This visit)

Did Not Perform: This visit

**Modalities:**

- Electric Stim, Unattended(This visit)

Did Not Perform: This visit

**Timed Code Total Time:**

- 44 Minutes

## Assessment

Pt re-educated on HEP and advised to not perform there-ex which have him lay on his surgical side. Pt verbalized understanding. Pt with improved endurance and ROM overall with continued high subjective c/o pain.

## Plan

**Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Feb 10, 2014 12:15:22



results physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Feb 17 2014 07:51am

P037

Note Date: Feb 10, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 9  
Cxl/Ns: 0

Employer: DELL  
Insured:

## Progress Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 6/10,

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 38

## Objective Examination

### Observations:

- Pt able to sit 8 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:**

### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

**Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:**

- Extension
- Flexion (increased pain)
- Side Bending Left
- Side Bending Right

**Range of Motion: Spine: Post-Treatment: Active Lumbosacral:**

- Extension
- Flexion

**Left**

Mild  
Mild  
Mild

**Jan 20, 2014**

50%  
75%  
75%  
75%

**Right**

Mild  
Mild  
Mild

**Feb 10, 2014**

100%  
100%  
100%  
100%  
  
Feb 10, 2014  
100%  
100%

## Assessment

Pt with continued high subjective c/o pain but improved endurance, lumbar ROM and decreased muscle guarding overall. Will continue to progress as tolerated.

## Plan

### Daily Plan:

- Continue w/ Current Rehabilitation Program.



**Therapy  
Referral**

I have read the above report and request that my patient:

- ☐ Continue with treatment program as indicated above.
- ☐ Continue treatment program for \_\_\_ days/week for \_\_\_ weeks.
- ☐ Revise treatment program as indicated: \_\_\_\_\_
- ☐ Progress to a home exercise program.
- ☐ Be discharged.
- ☐ Other: \_\_\_\_\_

Electronically authenticated.

**Please sign  
and return**

Lakota C. Hillis, PT(TN Lic: 8886), DPT  
Signed on Feb 10, 2014 12:18:21

Nicholas Cote DO

Date



results PHYSIOTHERAPY  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825  
Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Feb 17 2014 07:52am

P039

Note Date: Feb 10, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 9  
Cxl/Ns: 0  
Employer: DELL  
Insured:

## Progress Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

### Subjective Examination

#### Chief Complaint:

- Pain: Current Severity: 6/10.

#### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

#### Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:

- Score 38

### Objective Examination

#### Observations:

- Pt able to sit 8 minutes before position changed required secondary to pain.

#### Palpation: Lumbosacral Region: Musculature, Posterior:

Left

Right

#### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

Mild  
Mild  
Mild

Mild  
Mild  
Mild

#### Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

Jan 20, 2014

Feb 10, 2014

- Extension
- Flexion (increased pain)
- Side Bending Left
- Side Bending Right

50%  
75%  
75%  
75%

100%  
100%  
100%  
100%

#### Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

- Extension
- Flexion

Feb 10, 2014  
100%  
100%

### Assessment

Pt with continued high subjective c/o pain but improved endurance, lumbar ROM and decreased muscle guarding overall. Will continue to progress as tolerated.

### Plan

#### Daily Plan:

- Continue w/ Current Rehabilitation Program.



results PHYSIOTHERAPY Fax: 615-896-6825  
Patient: ARTHUR DAVIS  
Acct #: 124961

Feb 17 2014 07:52am P040

Note Date: Feb 10, 2014

**Therapy  
Referral**

I have read the above report and request that my patient:

- ☐ Continue with treatment program as indicated above.
- ☐ Continue treatment program for \_\_\_ days/week for \_\_\_ weeks.
- ☐ Revise treatment program as indicated: \_\_\_\_\_
- ☐ Progress to a home exercise program.
- ☐ Be discharged.
- ☐ Other: \_\_\_\_\_

Electronically authenticated.

**Please sign  
and return**

Lakota C. Hillis, PT(TN Lic: 8886), DPT  
Signed on Feb 10, 2014 12:18:21

Nicholas Cote DO

Date



results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Feb 17 2014 07:52am

P041

Visit Date: Feb 13, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 10  
Cxl/Ns: 0

Employer: DELL  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 4/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 48

## Objective Examination

### Observations:

- Pt able to sit 8 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:**

	Left	Right
<b>Guarding:</b>		
• Gluteus Maximus	Mild	Mild
• Piriformis	Mild	Mild
• Quadratus Lumborum	Mild	Mild

**Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:**

- |                            |      |
|----------------------------|------|
| • Extension                | 100% |
| • Flexion (increased pain) | 100% |
| • Side Bending Left        | 100% |
| • Side Bending Right       | 100% |

**Range of Motion: Spine: Post-Treatment: Active Lumbosacral:**

- |             |      |
|-------------|------|
| • Extension | 100% |
| • Flexion   | 100% |

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Manual Therapy Techniques	97140	1	8
• Therapeutic Activities	97530	2	25
• Therapeutic Procedure	97110	2	20

**Exercise Activities: Machines/Wts. (L. Quarter):**

- Machines/Free Weights 1

Time Elapsed: 20 Minutes, Description: see exercise log, Charge As:  
Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):**

- Closed Kinetic Chain 1

Time Elapsed: 25 Minutes, Description: see exercise log, Charge As:  
Therapeutic Activities, Billing Code: 97530.

**Manual Interventions: Vertebral Joint Segments:**

- Lumbosacral Spine (This visit)
- Vertebral Jt Seg Mobilization 1 (This visit)

Did Not Perform: This visit  
Did Not Perform: This visit



results PHYSIOTHERAPY Fax: 615-896-6325  
Patient: ARTHUR DAVIS  
Acct #: 124961

Feb 17 2014 07:52am

P042

Visit Date: Feb 13, 2014

- Vertebral Jt Seg Mobilization 2

**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

**Manual Interventions: Taping To Stabilize/Align:**

- Strapping Activity 1(This visit)

**Modalities:**

- Electric Stim, Unattended(This visit)

**Timed Code Total Time:**

- 53 Minutes

Time Elapsed: 8 Minutes, Grade: 3, Body Position: left side lying  
lumbar rotation, Pressure: Oscillatory, Technique 1: rotation, Charge  
As: Manual Therapy Techniques, Billing Code: 97140.

Did Not Perform: This visit

Did Not Perform: This visit

Did Not Perform: This visit

## Assessment

Progressed with additional activities with no adverse reaction. Will continue to progress as tolerated.

## Plan

**Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Feb 13, 2014 08:27:47



results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Feb 17 2014 07:53am

P043

Visit Date: Feb 13, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 10  
Cxl/Ns: 0

Employer: DELL  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

### Chief Complaint:

- Pain: Current Severity: 4/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

**Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:**

- Score 48

## Objective Examination

### Observations:

- Pt able to sit 8 minutes before position changed required secondary to pain.

**Palpation: Lumbosacral Region: Musculature, Posterior:** Left Right

### Guarding:

- |                      |      |      |
|----------------------|------|------|
| • Gluteus Maximus    | Mild | Mild |
| • Piriformis         | Mild | Mild |
| • Quadratus Lumborum | Mild | Mild |

### Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

- |                           |      |
|---------------------------|------|
| • Extension               | 100% |
| • Flexion(increased pain) | 100% |
| • Side Bending Left       | 100% |
| • Side Bending Right      | 100% |

### Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

- |             |      |
|-------------|------|
| • Extension | 100% |
| • Flexion   | 100% |

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Manual Therapy Techniques	97140	1	8
• Therapeutic Activities	97530	2	25
• Therapeutic Procedure	97110	2	20

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1
- Time Elapsed: 20 Minutes, Description: see exercise log, Charge As: Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1
- Time Elapsed: 25 Minutes, Description: see exercise log, Charge As: Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

- Lumbosacral Spine(This visit)
  - Vertebral Jt Seg Mobilization 1(This visit)
- Did Not Perform: This visit  
Did Not Perform: This visit





results PHYSIOTHERAPY Fax: 615-896-6825  
Patient: ARTHUR DAVIS  
Acct #: 124961

Feb 17 2014 07:53am

P044

Visit Date: Feb 13, 2014

- Vertebral Jt Seg Mobilization 2

Time Elapsed: 8 Minutes, Grade: 3, Body Position: left side lying;  
lumbar rotation; Pressure: Oscillatory, Technique 1: rotation, Charge  
As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

Did Not Perform: This visit

**Manual Interventions: Taping To Stabilize/Align:**

- Strapping Activity 1(This visit)

Did Not Perform: This visit

**Modalities:**

- Electric Stim, Unattended(This visit)

Did Not Perform: This visit

**Timed Code Total Time:**

- 53 Minutes

## Assessment

Progressed with additional activities with no adverse reaction. Will continue to progress as tolerated.

## Plan

**Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Feb 13, 2014 08:27:47



results Physiotherapy  
520 Highland Terrace, Suite A  
Murfreesboro, TN USA  
37130-2496  
Phone: (615) 896-6866  
Fax: (615) 896-6825

results PHYSIOTHERAPY Fax: 615-896-6825

Patient: ARTHUR DAVIS  
Acct #: 124961  
DOB: REDACTED  
Physician: Nicholas Cote DO  
Phys Fax: (615) 867-7945  
Physician: Not Specified  
Clinician: Lakota C. Hillis  
FSC: Commercial Insurance  
Case Mgr:  
Payor: AETNA  
Pol/Claim#:

Feb 17 2014 07:53am

P045

Visit Date: Feb 14, 2014  
Phys Phone: (615) 867-8010  
SSN: XXX-XX-XXXX  
Inj. Date: Jan 20, 2014  
Surg. Date:  
Visits: 11  
Cxl/Ns: 0

Employer: DELL  
Insured:

## Daily Note

**Diagnoses** Spine 7242 LUMBAGO  
7197 DIFFICULTY IN WALKING

## Subjective Examination

Feel more stiff today than painful.

### Chief Complaint:

- Pain: Current Severity: 0/10.

### Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

Questionnaires: Focus on Therapeutic Outcomes (FOTO): Physical Functional Status Measure: Intake: Patient:

- Score 48

## Objective Examination

### Observations:

- Pt able to sit 8 minutes before position changed required secondary to pain.

Palpation: Lumbosacral Region: Musculature, Posterior:

### Guarding:

- Gluteus Maximus
- Piriformis
- Quadratus Lumborum

Left

Mild  
Mild  
Mild

Right

Mild  
Mild  
Mild

Range of Motion: Spine: Pre-Treatment: Active Lumbosacral:

- Extension 100%
- Flexion(increased pain) 100%
- Side Bending Left 100%
- Side Bending Right 100%

Range of Motion: Spine: Post-Treatment: Active Lumbosacral:

- Extension 100%
- Flexion 100%

## Treatments

### Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Manual Therapy Techniques	97140	1	8
• Therapeutic Activities	97530	2	25
• Therapeutic Procedure	97110	2	18

### Exercise Activities: Machines/Wts.(L. Quarter):

- Machines/Free Weights 1

Time Elapsed: 18 Minutes, Description: see exercise log, Charge As:  
Therapeutic Exercise, Billing Code: 97110.

### Exercise Activities: Dynamic Training: C-K-C Activity (L. Quarter):

- Closed Kinetic Chain 1

Time Elapsed: 25 Minutes, Description: see exercise log, Charge As:  
Therapeutic Activities, Billing Code: 97530.

### Manual Interventions: Vertebral Joint Segments:

- Lumbosacral Spine(This visit)

Did Not Perform: This visit

Patient: ARTHUR DAVIS  
Acct #: 124961

Visit Date: Feb 14, 2014

- Vertebral Jt Seg Mobilization 1(This visit)
- Vertebral Jt Seg Mobilization 2

Did Not Perform: This visit

Time Elapsed: 8 Minutes, Grade: 3, Body Position: left side lying,  
lumbar rotation, Pressure: Oscillatory, Technique 1: rotation, Charge  
As: Manual Therapy Techniques, Billing Code: 97140.**Manual Interventions: Lower Quarter Soft Tissue:**

- Thoracolumbar PVM(This visit)

Did Not Perform: This visit

**Manual Interventions: Taping To Stabilize/Align:**

- Strapping Activity 1(This visit)

Did Not Perform: This visit

**Modalities:**

- Electric Stim, Unattended(This visit)

Did Not Perform: This visit

**Timed Code Total Time:**

- 51 Minutes

## Assessment

The client tolerated today's treatment/therapeutic activity with minimal complaints of pain and difficulty.

Pt progressing well towards goals.

Treatment Emphasis to focus on:

- Maximizing function related to: ADL's.

## Plan

**Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Electronically authenticated.

Lakota C. Hillis, PT(TN Lic: 8886),DPT  
Signed on Feb 14, 2014 10:35:57



## Fax Message

---

**To:** Scanning  
**Fax:** 8666671987  
**From:** Amor, Maribel  
**Date:** 2/17/2014 9:38 AM  
**Pages:** 1 of 4 (including this page)  
**Subject:** Treating sources

---

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If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

RE: 9452367

*Maribel Amor, MST  
Senior Disability Benefit Manager  
Aetna Life Insurance Company  
Ph: 954-693-2140  
Fax: 860-907-4494  
E-mail: AmorM@Aetna.com*

**Amor, Maribel**

---

**From:** Art Davis <coachart63@gmail.com>  
**Sent:** Friday, February 14, 2014 5:16 PM  
**To:** Amor, Maribel  
**Subject:** RE: Initial TP Claimant Interview 2010 (38).doc

**Dr. Cote**

**MURFREESBORO MEDICAL CLINIC & SURGICENTER**

1272 Garrison Drive

Murfreesboro, TN 37129-2598

Monday - Friday: 8:00am to 5:00pm

**If you need immediate assistance please call:**

**Toll Free:** 1-800-842-6692

**Local:** 615-893-4480

**Fax:** 615-895-6212

**Murfreesboro Results Physiotherapy**

*520 Highland Terrace Suite A*

*Murfreesboro, TN 37130*

*Phone: (615) 896-6866*

**From:** Amor, Maribel [<mailto:AmorM@aetna.com>]  
**Sent:** Friday, February 14, 2014 3:47 PM  
**To:** Art Davis  
**Subject:** RE: Initial TP Claimant Interview 2010 (38).doc

Dear Mr. Davis,

Please provide me with the phone, fax number for Dr. Cote and also for the physical therapy facility. Thanks, Maribel

*Maribel Amor, MST  
Senior Disability Benefit Manager  
Aetna Life Insurance Company  
Ph: 954-693-2140  
Fax: 860-907-4494  
E-mail: [AmorM@Aetna.com](mailto:AmorM@Aetna.com)*

---

**From:** Art Davis [<mailto:coachart63@gmail.com>]  
**Sent:** Friday, February 14, 2014 12:33 PM  
**To:** Amor, Maribel  
**Cc:** [coachart63@gmail.com](mailto:coachart63@gmail.com)  
**Subject:** RE: Initial TP Claimant Interview 2010 (38).doc

Good morning I have mailed my paperwork today and my drs office should have faxed paperwork.

**From:** Amor, Maribel [<mailto:AmorM@aetna.com>]  
**Sent:** Friday, February 14, 2014 9:13 AM  
**To:** [coachart63@gmail.com](mailto:coachart63@gmail.com)  
**Subject:** Initial TP Claimant Interview 2010 (38).doc

Arthur Davis  
Claim 9452367  
Dell Inc

Please complete the attached template and return to Aetna as soon as possible. Thanks, Maribel  
This e-mail may contain confidential or privileged information. If you think you have received this e-mail in error, please advise the sender by reply e-mail and then delete this e-mail immediately. Thank you. Aetna



## Fax Message

---

**To:** scanning

**Fax:** 8666671987

**From:** Amor, Maribel

**Date:** 2/14/2014 10:31 AM

**Pages:** 1 of 3 (including this page)

**Subject:** ISO

---

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This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.



Claim 9452367

*Maribel Amor, MST  
Senior Disability Benefit Manager  
Aetna Life Insurance Company  
Ph: 954-693-2140  
Fax: 860-907-4494  
E-mail: AmorM@Aetna.com*

Match #: 1

Reason for Match: SSN

**Record Type:** Property/Casualty Claim      **ISO File Number:** 0U001641892  
**Date of Loss:** 04/03/2004  
**Type of Policy:** Workers Compensation  
**Type of Loss:** Comprehensive  
**Location of Loss:** 2535 POWELL AVE  
                              : NASHVILLE, TN 37204  
**ISO Received:** 05/11/2004  
**Company:** SEDGWICK CLMS MANAGEMENT SVC INC  
**Address:** HOME DEPOT  
                              : 2455 PACES FERRY RD  
                              : ATLANTA, GA 30339  
**Claim Number:** 2423088

**Involved Party:** Claimant  
**Name:** DAVIS, ARTHUR  
**Address:** REDACTED  
                              : FRANKLIN, TN 37064  
**DOB:** REDACTED  
**SSN:** REDACTED (SSN ISSUED NY/1973-1974)  
**Phone:** REDACTED  
**Occupation:** NIGHT CREW  
**Injury/Damage:** BRUISE/CONTUSION - ELBOW

**Service Provider:** Lawyer For Claimant  
**Name:** MITCH GRISSIM & ASSOC  
**Address:** 325 UNION STREET  
                              : NASHVILLE, TN 37201  
**Phone:** (615) 255-9999

**Service Provider:** Medical Doctor (M.D.)  
**Name:** VANDERBILT UNIVERSITY HO  
**Address:** 1211 22ND AVENUE SOUTH  
                              : NASHVILLE, TN 37232  
**Phone:** (615) 322-1000

**Involved Party:** Insured  
**Name:** THE HOME DEPOT INC  
**Address:** 2455 PACES FERRY ROAD  
                              : ATLANTA, GA 30339  
**Tax ID:** 581853319



PO Box 14560  
Lexington, KY 40512-4560  
MARIBEL AMOR  
Senior LTD Claim Analyst  
Phone: 800-354-1779  
Fax: 1-866-667-1987

02/05/2014

ARTHUR DAVIS

REDACTED

MURFREESBORO TN - 37128

Group Control No:

Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

Dear MR. DAVIS:

Aetna Life Insurance Company ("Aetna") administers leaves of absence for Dell Inc under applicable state law and Dell Inc leave policies.

This letter concerns your disability plan with the above employer.

Our records indicate that you will soon reach the maximum number of weeks for short-term disability benefits under your plan. Please consult your Employee Booklet or Summary Plan Description to determine the maximum number of weeks that benefits are payable.

Please be sure to notify us as soon as possible if you return to work.

We are reviewing your claim to determine your eligibility for long-term disability (LTD) benefits. Certification of your short-term disability does not guarantee payment of LTD benefits. We will notify you shortly regarding the status of your LTD claim.

You previously received correspondence indicating your certified length of disability. As you may now be eligible for long-term disability benefits, we will periodically contact you for information to assess your continued disability.

At this time, we need you to complete, sign and return the forms below to Aetna within thirty (30) days from the date of this letter.

- **Aetna to Request Protected Health Information (PHI)**

In signing this form you authorize Aetna to obtain Protected Health Information necessary to process your disability claim.

- **Other Income Questionnaire**

This form shows types and amounts of "other income" benefits that you may now receive or may be eligible to receive. Please list all such other income benefits that you are now receiving or may be eligible to receive.

- **Authorization to Obtain Information**

In signing this form you authorize Aetna to obtain non-medical information from any agency or institution.

- **Work History and Education Questionnaire**

This form allows Aetna to assess your education and work history. Also, the form authorizes us to obtain and release information from past and present employers.

- **Reimbursement Agreement**

In signing this form, you authorize Aetna to recover any overpayments resulting from a retroactive Social Security benefit or from any other income source listed on the Disability Income Questionnaire.

- **Form W-4 or W-4S**

If you would like Federal Income taxes withheld from your monthly benefit, if applicable, Aetna will need your instruction in writing to do so. Please ensure that the form is completed in its entirety. Please note there is a minimum monthly withholding amount of \$88.00.

- **Authorization for Direct Deposit of Disability Benefit Payment**

In completing this form, you are requesting for your monthly long-term disability benefit to be electronically deposited into your checking or savings account.

Please have your attending physician complete and return the enclosed:

- **Attending Physician Statement**

This form provides Aetna with your physician's evaluation of your present condition, as well as the history, diagnosis, and treatment of your disability.

- **Capabilities and Limitations Worksheet**

This form provides Aetna with your physician's evaluation of your physical capabilities.

- **Attending Physician Behavioral Health Statement**

Disregard this form if not applicable to your condition. This form provides Aetna with your mental health provider's evaluation of your present condition, as well as the history, diagnosis, and treatment of your disability.

Note: If you have more than one physician or provider for your condition, a statement should be completed by each one. These forms can be reproduced.

These forms are required for all new LTD claims. All forms should be returned to this office in the envelope provided, as soon as possible, but no later than 30 days from the date of this letter.

Please be sure to include your claim number on any correspondence.

Should you have any questions regarding your claim, please call 800-354-1779 and an Aetna Customer Service Representative will be happy to assist you.

Sincerely,

MARIBEL AMOR  
Senior LTD Claim Analyst  
Aetna Life Insurance Company

Enclosure(s):  
Return Envelope  
Authorization to Obtain Information  
Authorization for Direct Deposit of Disability Benefit Payment  
Other Income Questionnaire  
Authorization to Share and Use Medical Information  
Authorization to Request Protected Health Information  
Work History and Education Questionnaire  
Capabilities and Limitations Worksheet  
Attending Physician Statement  
Behavioral Health Clinician Statement  
W4 - 2014  
W-4S 2014  
Reimbursement Agreement  
Reimbursement Agreement  
WorkAbility Portal Flyer  
>

Claim Number: 9452367



## Authorization To Obtain Information

Complete and sign the form using BLUE or BLACK ink.

Control Number: \_\_\_\_\_

Employee Year of Birth: \_\_\_\_\_

Employee Gender: ☐ Male ☐ Female

I DAVIS, ARTHUR, Claim Number \_\_\_\_\_,  
(please print full name – Last, First, Middle Initial)

hereby authorize any insurance company, third party administrator, government organization, employer and any of their agents performing services relating to any employee benefits or workers compensation or other organization, institution, or person that has any records or knowledge about me containing the following to release the information to the Aetna and/or its duly authorized representatives or agents:

- Financial information,
- Information pertaining to my credit history,
- Information pertaining to my academic performance, credits earned, or school-related activities,
- Other insurance benefits, or,
- Employment information and history (including job duties and earnings).

I understand that the information obtained by use of this authorization will be used for the purpose of evaluating and administering my claim for disability benefits.

This authorization is valid for the term of the policy or contract under which a claim has been submitted.

I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

I further authorize the Aetna and/or its authorized representatives or agents to request reports and information from the Social Security Administration regarding benefits, earnings and employer information, and any award, disallowance or termination relating to benefits.

Print Name (*Last, First, Middle Initial*)

Signature of Employee

Date Signed (*MM/DD/YYYY*)

If the person signing this authorization is not the member, describe relationship to the member.

If this authorization is being signed by the member's legal representative, you must furnish a copy of the Power of Attorney or other relevant document authorizing you to act on the member's behalf.

Mail this completed form to: **Aetna Life Insurance Company**  
PO Box 14560  
Lexington, KY 40512-4560  
Fax Number: **1-866-667-1987**

MI DT 48-045 WKAB-Generic  
GC-1499-5 (6-13) G

R-POD



Claim Number: 9452367

Employee Name

DAVIS, ARTHUR

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

MI DT 48-045 WKAB  
GC-1499-5 (6-13)

Pa



Claim Number: 9452367



## Authorization for EFT/Direct Deposit of Disability Benefit Payment

It's easy to set up EFT payments for disability benefits. All you have to do is complete the form below or you may visit us at <https://www.aetnadisability.com>. If you would prefer to complete via the form **please sign and return** the form to Aetna at the address below or you may also fax your information to **1-866-667-1987**.

**Aetna Life Insurance Company (Aetna)**  
**PO Box 14560**  
**Lexington, KY 40512-4560**  
**Phone: 800-354-1779**  
**Fax: 1-866-667-1987**

☐ New ☐ Change ☐ Cancel

### Employee Information - ALL fields must be completed.

Name		Telephone (     )	
Street Address			
City		State	ZIP Code
Social Security Number     -     -     -			

### Banking Information - ALL fields must be completed.

Name of Financial Institution		Telephone (     )
Please indicate: <input type="checkbox"/> Checking <u>OR</u> <input type="checkbox"/> Savings <u>and</u> <b>ATTACH</b> a copy of a blank check, marked "VOID <u>OR</u> provide the information below: Routing Number: _____ Account Number: _____		
<b>** Please attach a blank check from your Checking Account, marked "VOID" **</b>  If Electronic Funds Transfer (EFT) is available at your financial institution Aetna will send a pre-notification transaction to your financial institution for confirmation. Please allow time for EFT information to be processed by Aetna, which is approximately 10 calendar days from Aetna's receipt of this completed information. Upon completion of the pre-notification process, Aetna will transmit benefit payments via EFT. You may continue to receive benefit payments via check until this process is complete.		

ATTACH HERE

### Authorization Agreement

I authorize Aetna to initiate electronic funds transfers to my account at the financial institution associated with the routing number I entered for all benefit payments on my behalf. This agreement will remain in effect until I provide written notice to withdraw from the direct deposit service or until Aetna or my employer notifies me that this service has been terminated. I understand that I must allow approximately 10 calendar days from Aetna's receipt of this information for my instructions to be executed. If Aetna credits more money to said account than the correct benefit amount to which I am entitled due to duplicate or erroneous funds transfers, I authorize the financial institution to allow Aetna to reverse the transactions. If the reversal is denied by my financial institution, I agree to repay said amounts to Aetna.

<b>Authorized Signature(s)</b>	<b>Date</b>
--------------------------------	-------------

EFT GR-68735 (2-12) C

R-POD



Claim Number: 9452367



## Other Income Questionnaire Disability Benefits

Mail this completed form to:  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: 800-354-1779  
Fax: 1-866-667-1987

- Please complete this form immediately so we can accurately determine your benefits.
- Provide all information relating to your actual or expected entitlement to income from all sources (**excluding** Aetna Disability Benefits) to avoid processing delays and/or overpayment of benefits.
- **Please check all boxes that apply.**
- Complete and sign the form using BLUE or BLACK ink.

Employee's Name (Last, First, Middle Initial) <b>DAVIS, ARTHUR</b>		Claim Number
Control Number	Employee Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Year of Birth

**This section must be completed:**

Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed If married, spouse's date of birth (MM/DD/YYYY) _____		
Do you have any dependent children? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, youngest child's date of birth (MM/DD/YYYY) _____		
<input type="checkbox"/> Yes <input type="checkbox"/> No <b>I am currently receiving other income.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>I have received other income since the onset of my disability.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>I have received income from work activity since the onset of my disability.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>I have applied for and/or received other income as defined below.</b>		
Provide information as to all of the following types and/or sources of other income: <ul style="list-style-type: none"><li>• Salary/Wages from present employer</li><li>• Income from self-employment</li><li>• Rehabilitation Earnings</li><li>• Pension/Retirement (including Canada)</li><li>• Part-time Earnings</li><li>• Veteran's Benefits</li><li>• Unemployment Compensation</li><li>• Jones Act or Maritime Doctrine</li><li>• Recoveries from Third Party causing disability</li><li>• Social Security Disability - Primary</li><li>• Social Security Disability - Family</li><li>• Social Security Retirement</li><li>• Social Security Widow/Widowers Benefit</li><li>• State Disability Plans</li><li>• Workers' Compensation - Periodic/Lump Sum</li><li>• No-Fault Automobile Coverage</li><li>• Railroad Retirement</li><li>• Private Group Disability benefits</li></ul>		
<b>List other income you are receiving or have applied for:</b>		
Source of Income	Effective Date of Benefits (MM/DD/YYYY)	Benefit Amount and Frequency
Signature		Date (MM/DD/YYYY)

Complete back →

WKAB

GC-1503-26 (8-13) C

R-POD





Claim Number: 9452367

Employee's Name (Last, First, Middle Initial)  
DAVIS, ARTHUR

### Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Employee's Signature

Date (MM/DD/YYYY)

WKAB  
GC-1503-26 (8-13) C

Pa





Claim Number: 9452367



## Authorization to Share and Use Medical Information

Mail this completed form to:  
Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Fax: **1-866-667-1987**

I allow all doctors, hospitals, other health care providers, pharmacy, pharmacy benefit managers, government agencies, insurers, employers, schools, training facilities, health plans, policyholders, contract holders, vendors, health and benefit plan administrators or their successors ("Records Holders") to give out my medical information as explained on this Authorization form.

This information includes, but is not limited to, any records or facts about my medical condition, treatment, supplies, employment, vocation, education training, income, and other insurance coverage including benefits paid ("Information"). This Information may also include diagnosis, treatment and education related to drug and/or alcohol abuse, HIV/AIDS or other communicable or sexually-transmitted disease, as well as behavioral health conditions (but does not include psychotherapy notes).

I allow the Records Holders to give my Information to the following individuals or entities ("Benefit Managers"): the employer named below, Aetna Life Insurance Company, their benefit plan or claims administrator(s), their related companies, contractors, investigators, attorneys, and service consultants, authorized union representatives, health care providers treating or evaluating me or my claim, and other individuals or entities involved in administering, evaluating, analyzing and managing the plan or my claim.

I allow the Benefit Managers to use and give out the Information only to evaluate, analyze, manage and/or administer a claim for short term disability benefits, long term disability benefits, salary continuation, leave under the federal Family and Medical Leave Act, local and state leave laws, workers' compensation and/or any other health benefit program, fitness for duty, other work accommodation programs, or leave benefits offered by and through my employer ("Benefits Program"). I also allow the Benefits Managers to give my Information to any other person or entity if needed to find out whether I am eligible for benefits, to manage my claim, or to run the Benefits Program.

I understand that Information disclosed to Benefit Managers pertaining to certain alcohol or drug abuse treatment or HIV/AIDS or other communicable or sexually-transmitted disease is protected by federal (42 CFR Part 2) and state confidentiality rules and statutes, which prohibit any further disclosure of this information without my express written consent, or as otherwise permitted by such rules and statutes. I understand that a general authorization for the release of medical or other information is NOT sufficient for release of these types of records. Therefore:

- ☐ If any of my records contain information about alcohol or drug abuse, then, by checking this box, I hereby expressly allow my Benefits Managers to use or give out such information to evaluate, analyze, manage and/or administer the Benefits Program. I understand that the federal rules restrict any use of the Information to criminally investigate or prosecute any drug or alcohol abuse patient.
- ☐ If any of my records contain information about HIV/AIDS or other communicable or sexually transmitted disease, then, by checking this box, I hereby expressly allow my Benefits Managers to use or give out such information to evaluate, analyze, manage and/or administer the Benefits Program.

The Benefits Managers will tell those receiving Information that the Information is confidential. The Information provided to Aetna will not be used for any purpose other than its intended use stated above. I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it and it may be re-disclosed by the Benefit Managers.

Unless revoked earlier, I understand that this permission lasts twelve (12) months after my claim is processed or twelve (12) months after the end of my coverage under the Benefits Program, whichever is longer, unless law requires a shorter period. If I change my mind about this Authorization before that time is up, I can tell my Records Holders and Benefits Managers in writing that I do not want them to share any more information. If I revoke my Authorization by telling them in writing to stop sharing information, it will not change any actions they took before I revoked my permission. If I do not sign this Authorization, it will not affect how my health care providers treat me. However, if I do not sign, the Benefits Managers may not be able to review my claim and cannot find out whether I am eligible for benefits. This may result in denial of my request for benefits.

The Information released under this Authorization can be submitted to the Benefits Managers electronically, by phone or fax, or by mail. I know I can see or copy the records given to the Benefits Managers. I agree that a copy of this Authorization may be treated as a signed original.

### NOTICE TO RECIPIENT(S) OF INFORMATION:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. *Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.*

Claimant's Name	Date of Birth	Date
Claimant's or Legal Representative's Signature	Legal Representative's Name and Relationship	
Employer's Name		

WKAB

GR-68320 (6-13) I

R-POD



Claim Number: 9452367



## Authorization For Aetna To Request Protected Health Information Necessary To Process A Disability Claim

Please Read The Following Carefully Before Completing Your Authorization. You May Refuse To Sign This Authorization. (See Section 6.)

**1. Member Information (Information About Person For Whom This Authorization Is Requested.)**

Last Name DAVIS		First Name ARTHUR		Middle Initial
Claim Number		Year of Birth	Daytime Telephone Number (include area code)	
Street Address		City, State and ZIP		

**2. This form requests a Member's unconditioned authorization for Aetna to ask another person or organization to disclose Member's Protected Health Information ("PHI") to Aetna for the purpose of processing my disability claim.**

**3. The specific PHI we are asking you to authorize Aetna to request is (This section completed by Aetna.)**

*Any and all medical information including but not limited to information which relates to psychiatric or mental health, drug, substance abuse, and/or HIV Infection, including AIDS and related illnesses, concerning health care, advice and treatment and prescription history records (including but not limited to, medical records, histories, physical or diagnostic examinations reports and treatment notes).*

**4. If you prefer to authorize the request of only selected categories of information, please indicate below which types of information may be disclosed. (This section completed by Member)**

<input type="checkbox"/> Health (This includes medical, dental, pharmacy, vision, and flexible spending account information)
<input type="checkbox"/> Behavioral Health (e.g., mental health, drug and alcohol abuse treatment)
<input type="checkbox"/> Disability <input type="checkbox"/> Life Insurance <input type="checkbox"/> Long Term Care <input type="checkbox"/> Workers' Compensation
<input type="checkbox"/> Other: (please specify) _____

**5. By signing this form, you will authorize Aetna to request PHI described above from the following persons or organizations (or classes of persons or organizations.)**

*Service Providers, including but not limited, to physicians, therapists, medical practitioners, health care professionals, workers' compensation professionals, diagnostic facilities, hospitals, clinics and pharmacy related service organizations (including individuals or facilities which provide rehabilitation services or treatment).*

**6. Expiration of this Authorization**

This authorization is valid throughout the processing and any term of your disability claim unless you indicate a shorter period below.	
_____ mm/dd/yyyy	through _____ mm/dd/yyyy

Please review and complete important information on the reverse of this form.

WKAB  
GR-67940-26 (8-13) D

Page 1 of 3  
R-POD



Claim Number: 9452367

<b>Employee Name</b> ARTHUR DAVIS
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**7. Important: Your signature below means that you understand and agree to the following:**

- You authorize Aetna to request from the persons or organizations named above, the PHI described above, for the purposes stated above.
- The information to be disclosed may be protected by law. Information disclosed under this authorization may be re-disclosed and no longer protected by federal privacy regulations.
- Failure to complete this form may prevent Aetna from receiving information necessary for the processing of your disability claim, which may result in a disability claim denial. Failure to complete this form will not however impact your receipt of medical services from providers.
- You may revoke this Authorization at any time by notifying Aetna in writing, but please note that actions Aetna has taken before we received your revocation will still be valid under this authorization.
- You may receive a copy of this form if you request it in writing from the address listed below.

**8. Signature of Member or Legal Representative**

Signature of Member or Legal Representative	Date
Print Name	

**If not the Member,** describe your relationship to the Member:

- ☐ Caregiver  
☐ Legal Representative  
☐ Other: \_\_\_\_\_

If Member's legal representative is signing this Authorization, you must furnish a copy of the health care power of attorney, or other relevant document designating you as the representative.

**NOTICE TO RECIPIENT(S) OF INFORMATION (Section 2. above):**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. ***Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.***

**Return this completed form to:** **Aetna Life Insurance Company**  
PO Box 14560  
Lexington, KY 40512-4560

**Telephone Number:** 800-354-1779  
**Fax Number:** 1-866-667-1987

**WKAB**  
GR-67940-26 (8-13) D

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Claim Number: 9452367

Employee Name DAVIS, ARTHUR
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#### 9. Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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Claim Number: 9452367



## Work History and Education Questionnaire

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

Instructions: Please print, answer all questions, date and sign the release. Complete and sign the form using BLUE or BLACK ink.

<b>1. Employee Information</b>	Name (Last, First, Middle Initial) <b>DAVIS, ARTHUR</b>		Social Security Number
	Control Number	Year of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

<b>2. Education</b>	Highest Level Achieved
	Grade <input type="checkbox"/> 1-8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> GED College <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
	Post Graduate Work
	List Degrees, Majors
	List Any Additional Training
	List Any Certifications or Licenses
Military Services/Training	

<b>3. Work History</b>	Current Job You Are Disabled From	Date Hired (MM/DD/YYYY)	Salary
	Description of Your Job (e.g., Tasks/Functions Performed; Include: Equipment, Tools, Applications, Time Demands, Mental Demands, Stress Level)		
	List Those Duties You Now Cannot Perform		
	Supervision of Others <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Hours In Your Workday <input type="checkbox"/> 8 <input type="checkbox"/> 10 <input type="checkbox"/> 12 Other _____	
	Other Job Titles Held:		
	In Your Work Day, How Much Time (Hours) Did You Spend: A. Sitting <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> Continuously B. Standing <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> Continuously C. Walking <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> Continuously		
On The Job You:			
	Occasionally	Frequently	Continually
1. Bend/Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Reach Above Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Push/Pull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Lift Up To 10 Pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-25 Pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26-50 Pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50 Pounds or More	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do You Use Your Hands And/Or Feet For Repetitive Movements? (E.G. Operating Foot Controls)			
Right Hand:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Right Foot:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Left Hand:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Left Foot:	<input type="checkbox"/> Yes <input type="checkbox"/> No

WKAB  
GC-1501-26 (7-13)

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Claim Number: 9452367

Employee Name (Last, First, Middle Initial) DAVIS, ARTHUR	Employee Social Security Number
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Please provide complete work history information for the past 15 years (list chronologically and use additional paper if necessary).

<b>4. Other Work History</b>	Employer	Job Title	Employed From _____ To _____	Salary
	Description of your job			
	Training Received			
	Equipment, Tools, Applications, Time Demands, Mental Demands, Stress Level			
	Supervision of others as part of your job <input type="checkbox"/> Yes <input type="checkbox"/> No		Other Job Titles Held	
	Employer	Job Title	Employed From _____ To _____	Salary
	Description of your job			
	Training Received			
	Equipment, Tools, Applications, Time Demands, Mental Demands, Stress Level			
	Supervision of others as part of your job <input type="checkbox"/> Yes <input type="checkbox"/> No		Other Job Titles Held	
	Employer	Job Title	Employed From _____ To _____	Salary
	Description of your job			
	Training Received			
	Equipment, Tools, Applications, Time Demands, Mental Demands, Stress Level			
	Supervision of others as part of your job <input type="checkbox"/> Yes <input type="checkbox"/> No		Other Job Titles Held	

Please list your outside of work activities (e.g. Sports, Activities, Hobbies)

<b>5. Additional Information</b>	Before your Disability:
	After your Disability:

<b>6. Certification</b>	I hereby certify that the foregoing statements and answers are complete and true to the best of my knowledge and belief. Date (MM/DD/YYYY) _____ Signed Employee _____
-------------------------	---

<b>7. Authorization</b>	To my present employer and all previous employers: I hereby authorize my present and past employers to provide Aetna or its representative with a description of all job-related duties and functions I performed while actively employed. I further authorize Aetna or its representative to release this information to vocational or clinical specialists it utilizes during the course of its administration of my disability claim. A copy of this authorization shall be as valid as the original. Date (MM/DD/YYYY) _____ Signed Employee _____
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Claim Number: 9452367

Employee Name (Last, First Middle Initial) DAVIS, ARTHUR	Employee Social Security Number
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**Misrepresentation**

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Employee's Signature	Date (MM/DD/YYYY)
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WKAB  
GC-1501-26 (7-13)

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Claim Number: 9452367



# Capabilities and Limitations Worksheet

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

Employee Name (Last, First, Middle Initial) <b>DAVIS, ARTHUR</b>		Social Security Number	Year of Birth
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Job Title		Control Number
Current Diagnosis _____ _____		Medications: _____ _____	

Indicate the percent of the day the following activities can be performed:  
(**O**ccasional 1-33% or .5-2.5 hrs. **F**requent 34-66% or 2.6-5.0 hrs. **C**ontinuous 67-100% or 5.1-8 hrs. or **N**ever)

	<b>O</b>	<b>F</b>	<b>C</b>	<b>N</b>		<b>O</b>	<b>F</b>	<b>C</b>	<b>N</b>
Climbing -	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hand Grasping <u>  </u> R <u>  </u> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Firm Hand Grasping <u>  </u> R <u>  </u> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fine Manipulation <u>  </u> R <u>  </u> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gross Manipulation <u>  </u> R <u>  </u> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repetitive Motion <u>  </u> R <u>  </u> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting <u>  </u> R <u>  </u> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Standing <u>  </u> R <u>  </u> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forward reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stooping <u>  </u> R <u>  </u> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walking <u>  </u> R <u>  </u> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Maximum weight patient is capable of lifting: <table style="width: 100%;"> <thead> <tr> <th></th> <th><b>O</b></th> <th><b>F</b></th> <th><b>C</b></th> <th><b>N</b></th> </tr> </thead> <tbody> <tr><td>1 - 5 lbs.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>6 - 10 lbs.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>11 - 20 lbs.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>21 - 35 lbs.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>36 - 50 lbs.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>51 - 75 lbs.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>75 - 100 lbs.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>100 lbs. +</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>		<b>O</b>	<b>F</b>	<b>C</b>	<b>N</b>	1 - 5 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 - 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 - 20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21 - 35 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	36 - 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51 - 75 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	75 - 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	100 lbs. +	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Approved Head and Neck Movements: <table style="width: 100%;"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr><td>Static Position</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Frequent Flexing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Frequent Rotation</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> Can the Patient operate: <table style="width: 100%;"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr><td>A Motor Vehicle</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Hazardous Machine</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Power Tools</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>		Yes	No	Static Position	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Flexing	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Rotation	<input type="checkbox"/>	<input type="checkbox"/>		Yes	No	A Motor Vehicle	<input type="checkbox"/>	<input type="checkbox"/>	Hazardous Machine	<input type="checkbox"/>	<input type="checkbox"/>	Power Tools	<input type="checkbox"/>	<input type="checkbox"/>
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Limitations to: Speaking _____ hrs. Vision (explain) _____ Depth Perception _____ Hearing (explain) _____	Exposure Limitations: Yes No Yes No Heat <input type="checkbox"/> <input type="checkbox"/> Dust <input type="checkbox"/> <input type="checkbox"/> Cold <input type="checkbox"/> <input type="checkbox"/> Fumes <input type="checkbox"/> <input type="checkbox"/> Dampness <input type="checkbox"/> <input type="checkbox"/> Chemicals <input type="checkbox"/> <input type="checkbox"/> Noise <input type="checkbox"/> <input type="checkbox"/> Radiation <input type="checkbox"/> <input type="checkbox"/>
---	---

Total # of hours patient capable of working per day: 12 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐  
 Duration of restrictions: \_\_\_\_\_ Care Complete: Yes ☐ No ☐ Next Appointment: \_\_\_\_\_  
 Additional Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Physician's Signature		Date (MM/DD/YYYY)
Physician Name		Specialty
Phone Number		Fax Number
Address		

WKAB  
GC-1500-26 (7-13)

Page 1 of 2



Claim Number: 9452367

Employee Name (Last, First Middle Initial) <b>Required</b> DAVIS, ARTHUR
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### Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Employee's Signature	Date (MM/DD/YYYY)
----------------------	-------------------



Claim Number: 9452367



## Attending Physician Statement

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: 800-354-1779  
Fax: 1-866-667-1987

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

- 1. Patient Instructions** – The Physician will complete Sections 2 through 7.  
The Patient will complete Sections 1 and 8.  
The Patient should also fill in their name at the top of Pages 2 and 3.

The **Patient** is responsible for completing this section and for **ensuring** that their **Attending Physician completes the remainder of this statement**. The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. **If you have any questions, please call 800-354-1779.**

- (a) Control Number \_\_\_\_\_  
(b) DAVIS, ARTHUR / REDACTED / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Patient Name (Last, First, Middle Initial) Social Security Number Year of Birth Height Weight (lbs)  
(c) Patient Gender ☐ Male ☐ Female  
(d) \_\_\_\_\_  
Patient Home Address – Required (Current No., Street, Town, State, ZIP – no PO boxes) ☐ Check if New  
(e) Mailing Address, if different from Home Address \_\_\_\_\_  
(f) Patient Employer Name/City/State Dell Inc  
(g) Patient Telephone Number \_\_\_\_\_ ☐ Check if New  
(h) Job Title/Occupation Inside Sales Account Mgmt lii  
(i) Type of Claim: ☐ Short Term Disability ☐ Long Term Disability ☐ Waiver of Premium  
☐ Long Term / Permanent Total Disability

## 2. Physician Instructions

The **Attending Physician** should **complete the items below**, based upon a **recent examination**. Attach additional documentation as needed. If you have any questions, please call **800-354-1779**.

**Please complete form in its entirety and fax to 1-866-667-1987.**

**Pages 2 and 3 MUST be completed before faxing.**

## 3. Impairing Diagnosis & Treatment

- (a) **For medical reasons, the patient will need to be absent from work due to a disability beginning on** \_\_\_\_\_ **and ending on** \_\_\_\_\_ .  
(MM/DD/YYYY) (MM/DD/YYYY)  
(b) Primary Diagnosis \_\_\_\_\_ Primary ICD Code \_\_\_\_\_  
Secondary Diagnosis \_\_\_\_\_ Secondary ICD Code \_\_\_\_\_  
Other Diagnoses \_\_\_\_\_ Other ICD Codes \_\_\_\_\_  
(c) Height \_\_\_\_\_ Weight \_\_\_\_\_ Date Measured (MM/DD/YYYY) \_\_\_\_\_  
(d) If Pregnancy related, delivery or expected due date Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Delivery Type: ☐ Vaginal ☐ Cesarean  
(e) Surgery Date \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Primary Procedure \_\_\_\_\_ Primary CPT Code \_\_\_\_\_  
Secondary Procedure \_\_\_\_\_ Secondary CPT Code \_\_\_\_\_  
Other Procedures \_\_\_\_\_ Other CPT Codes \_\_\_\_\_  
(f) Medication(s)/Dose/Frequency \_\_\_\_\_  
Impairment from medication effects \_\_\_\_\_  
(g) Is patient still under your care for this condition? ☐ Yes ☐ No Date service terminated \_\_\_\_\_  
(MM/DD/YYYY)  
(h) Treatment Summary \_\_\_\_\_  
(i) Office Visit Dates: First \_\_\_\_\_ Last \_\_\_\_\_ Next \_\_\_\_\_ Frequency of appointments \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY) (MM/DD/YYYY)  
(j) Was patient recently hospitalized? ☐ No ☐ Yes Date hospitalized: Admit \_\_\_\_\_ Discharge \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)  
(k) Hospital Name/City/State \_\_\_\_\_

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Patient Name (Last, First, Middle Initial) **Required**

DAVIS, ARTHUR

**4. History**

(a) Symptoms: \_\_\_\_\_

(b) Date symptoms first appeared or accident happened Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

(c) Has patient ever had same or similar condition? ☐ No ☐ Yes State when and describe. \_\_\_\_\_

(e) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown

(f) Other Treating Physicians

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**5. Abilities/Limitations**

(a) **Patient is: Place remarks in item (d) below, if applicable.**

- Competent to endorse checks and direct the use of proceeds thereof .... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to work with others ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to give supervision ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to work cooperatively with others in group setting ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to do? **Select one: Place remarks in item (d) below, if applicable.**
  - ☐ **Heavy work** activity. No limitations of functional capacity.
  - ☐ **Medium work** activity. Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly.
  - ☐ **Light work** activity. Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently.
  - ☐ **Sedentary work** activity. Moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. (Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.)
  - ☐ **No ability to work.** Severe limitation of functional capacity; incapable of minimal activity.
  - ☐ **Other.** Place remarks in item (d) below.

(b) **What medical restrictions/limitations are you placing on patient? (Activities of Daily Living, Driving, Lifting, Pulling, Pushing, and Amounts, etc.)** \_\_\_\_\_

\_\_\_\_\_

• Number of Hours patient is capable of working in a day: ☐ 12 ☐ 10 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐ 1 Hour/Day

• Number of Days per week patient is able to work: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week

• Date you prescribed restriction on work activities: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

• How long are these restrictions/limitations in effect? \_\_\_\_\_ ☐ No Longer

Days Weeks Months

• Estimated return to work date? \_\_\_\_\_ Modified Duty \_\_\_\_\_ Full Duty \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

(c) **Objective findings that substantiate impairment** (current laboratory, physical and/or mental status examination and other testing) \_\_\_\_\_

\_\_\_\_\_

(d) Other/Comments \_\_\_\_\_

\_\_\_\_\_

**6. Current Status**

(a) Patient has ☐ Improved ☐ Stabilized ☐ Regressed ☐ Not Applicable

(b) Is there a medical contraindication for patient to participate in Vocational Rehabilitation (job training) programs?  
☐ No ☐ Yes, please explain \_\_\_\_\_

(c) In your opinion, is your patient motivated to return to work? \_\_\_\_\_

**7. Physician Information**

Attending Physician's Name ( <i>Print</i> )	Degree	Specialty
Address (No. Street, City, State, ZIP Code)	Telephone Number	Fax Number
Signature		Date (MM/DD/YYYY)

WKAB

GC-1486-26 (7-13) C



Claim Number: 9452367

Patient Name (Last, First, Middle Initial) **Required**  
DAVIS, ARTHUR

#### 8. Regulation Notice

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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WKAB  
GC-1486-26 (7-13) C

Pa



# aetna® Behavioral Health Clinician Statement

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Fax: 1-866-667-1987

Patient Name	Provider Name	Clinical Manager Name
Patient Year of Birth	Provider Telephone Number	Clinical Manager Telephone Number
Patient Case Number Claim Number: 9452367	Provider Fax Number	Clinical Manager Fax Number

Patient Occupation:  
Inside Sales Account Mgmt Iii

Provide detailed examination findings that would prohibit the claimant from performing: ☐ Any Reasonable Occupation ☐ Own Occupation

1. Have you recommended that your patient stay home from work on disability? ☐ Yes ☐ No

2. Please specify the recommended Start Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ End Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Diagnostic Impressions

Axis 1: \_\_\_\_\_ Axis 3: \_\_\_\_\_ Axis 5: GAF Score Current \_\_\_\_\_  
Axis 2: \_\_\_\_\_ Axis 4: \_\_\_\_\_ Prior to Work Leave \_\_\_\_\_

## Patient's Perspective

The patient has conceptualized the following barriers in returning to work:

☐ Increase in work demand ☐ Conflicts with supervisor ☐ Anticipation of relapse ☐ Recent unfavorable work evaluation  
☐ Dissatisfaction with the job ☐ Medication complications ☐ Other: \_\_\_\_\_

Patient's Progress: ☐ Improved ☐ Stable ☐ Regressed

## Risk to Self/Others

1. Suicidal ideation? ☐ Yes ☐ No If Yes, please describe plan/intent: \_\_\_\_\_

2. Homicidal ideation? ☐ Yes ☐ No If Yes, please describe plan/intent: \_\_\_\_\_

3. Have you and the patient agreed upon measures to be taken should the threat to harm self/others becomes imminent? ☐ Yes ☐ No If Yes, please describe: \_\_\_\_\_

4. Is the patient able to report reasons for not harming self/others? ☐ Yes ☐ No If Yes, please describe: \_\_\_\_\_

## Emotional Functioning

1. Emotional state/mental status during exam (Describe affect, mood, range, lability, congruency with content). \_\_\_\_\_

2. Requires assistance to compose self? ☐ Yes ☐ No, If Yes, please describe: \_\_\_\_\_

3. Panic attacks? ☐ Yes ☐ No

a. Symptoms reported: \_\_\_\_\_

b. Frequency of panic attacks/Duration of each attack: \_\_\_\_\_

c. Intervention used: \_\_\_\_\_

d. Panic Attack ever observed in exam?: ☐ Yes ☐ No, If Yes, please describe: \_\_\_\_\_

Additional Examination Findings/Notes

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Claim Number: 9452367

Patient Name	Provider Name	Clinical Manager Name
--------------	---------------	-----------------------

#### Cognitive Functioning

1. Able to follow a three step command?	<input type="checkbox"/> Yes <input type="checkbox"/> No, please provide exam details:
2. Able to perform five operations of Serial 7's or 3's?	<input type="checkbox"/> Yes <input type="checkbox"/> No, please provide exam details:
3. Memory Functions:	<input type="checkbox"/> Digit span forward = _____ <input type="checkbox"/> Digit span backwards = _____ <input type="checkbox"/> 4 unrelated words after 5 minutes <input type="checkbox"/> Other measurement(s) _____
4. Applied focus and concentration in session for periods of:	<input type="checkbox"/> 30-50 min. <input type="checkbox"/> 15-30 min. <input type="checkbox"/> 5-10 min. <input type="checkbox"/> less than 5 min.
5. Expressed his/her current circumstances and responded to direct questions appropriately?	<input type="checkbox"/> Yes <input type="checkbox"/> No, please describe
6. Reasoning and/or Judgment:	<input type="checkbox"/> Within normal limits <input type="checkbox"/> Impaired, please describe:
7. Delusional ideation evident?	<input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:
8. Hallucinations reported?	<input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:
9. Was a mini mental status exam completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide score:
Additional Examination Findings/Notes	

#### Behavioral Observations

1. Behaviors observed during exam. Please provide specific details.	
2. Psychomotor activity:	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Impaired, please describe:
3. Presented with appropriate dress and hygiene in session?	<input type="checkbox"/> Yes <input type="checkbox"/> No, please describe:
4. Difficulty with impulse control?	<input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:
5. Speech:	<input type="checkbox"/> Slurred <input type="checkbox"/> Pressured <input type="checkbox"/> Stammering <input type="checkbox"/> Loud <input type="checkbox"/> Soft <input type="checkbox"/> Over Productive <input type="checkbox"/> Under Productive
Additional Examination Findings/Notes	

#### Activities of Daily Living

1. Is patient currently performing:	<input type="checkbox"/> Volunteer Work <input type="checkbox"/> Attending School <input type="checkbox"/> Self-Employed <input type="checkbox"/> Work at a Lesser Demanding Job <input type="checkbox"/> No Work Activities in Any Capacity
2. Significant weight/appetite changes?	<input type="checkbox"/> Yes <input type="checkbox"/> No Gain/loss within _____ (Time frame)
3. Sleep disturbances?	<input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:
4. Socialization problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:
5. Cleans/Maintains residence?	<input type="checkbox"/> Yes <input type="checkbox"/> No Performs routine shopping? <input type="checkbox"/> Yes <input type="checkbox"/> No Pay bills? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is patient able to safely operate an automobile or other motorized vehicle?	<input type="checkbox"/> Yes <input type="checkbox"/> No, please describe:
Additional Examination Findings/Notes	

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Claim Number: 9452367

Patient Name	Provider Name	Clinical Manager Name
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**Treatment**

	Start Date	End Date	Days Per Week	Frequency	Last Visit	Next Visit
<input type="checkbox"/> Inpatient Care						
<input type="checkbox"/> Partial Hospitalization Programs						
<input type="checkbox"/> Intensive Outpatient (IOP)						
<input type="checkbox"/> Outpatient Psychotherapy						
<input type="checkbox"/> Medication Management						

Additional Examination Findings/Notes

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medications**

1. Please list all current medications.

2. Any recent changes in medications? ☐ Yes ☐ No If Yes, please describe: \_\_\_\_\_

3. Medication side effects? ☐ Yes ☐ No If Yes, please describe: \_\_\_\_\_

Additional Examination Findings/Notes

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Referrals**

Have you referred your patient to any other providers? ☐ Yes ☐ No If Yes, please provide name and contact information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Claimant Return To Work Status**

Is your patient?

☐ Able to return to work FULL DUTY without modification. Full Duty release to return to work date: \_\_\_\_\_

☐ Unable to work currently. Projected/estimated return to work by: \_\_\_\_\_

☐ Able to work with modifications. Modified release to return to work date: \_\_\_\_\_

Please include specific modifications recommended: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature/Exam Date**

Signature	Date Exam Completed
Print Name	Date Form Completed
Credentials	

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

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**Form W-4 (2014)**

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

**Exemption from withholding.** If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$1,000 and includes more than \$350 of unearned income (for example, interest and dividends).

**Exceptions.** An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than \$1,000,000.

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

**Head of household.** Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners or multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

**Nonresident alien.** If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

**Future developments.** Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at [www.irs.gov/w4](http://www.irs.gov/w4).

**Personal Allowances Worksheet (Keep for your records.)**

<b>A</b>	Enter "1" for <b>yourself</b> if no one else can claim you as a dependent . . . . .	<b>A</b> _____
<b>B</b>	Enter "1" if: <div style="display: inline-block; vertical-align: middle;"> <ul style="list-style-type: none"> <li>• You are single and have only one job; or</li> <li>• You are married, have only one job, and your spouse does not work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul> </div>	<b>B</b> _____
<b>C</b>	Enter "1" for your <b>spouse</b> . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . .	<b>C</b> _____
<b>D</b>	Enter number of <b>dependents</b> (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b> _____
<b>E</b>	Enter "1" if you will file as <b>head of household</b> on your tax return (see conditions under <b>Head of household</b> above) . . . . .	<b>E</b> _____
<b>F</b>	Enter "1" if you have at least \$2,000 of <b>child or dependent care expenses</b> for which you plan to claim a credit . . . . .	<b>F</b> _____
<b>G</b>	<b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$65,000 (\$95,000 if married), enter "2" for each eligible child; then <b>less</b> "1" if you have three to six eligible children or <b>less</b> "2" if you have seven or more eligible children. • If your total income will be between \$65,000 and \$84,000 (\$95,000 and \$119,000 if married), enter "1" for each eligible child . . . . .	<b>G</b> _____
<b>H</b>	Add lines A through G and enter total here. ( <b>Note.</b> This may be different from the number of exemptions you claim on your tax return.) ►	<b>H</b> _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

----- Separate here and give Form W-4 to your employer. Keep the top part for your records. -----

<b>Form W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b> ► Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.		OMB No. 1545-0074 <b>2014</b>
<b>1</b> Your first name and middle initial <b>ARTHUR</b>		<b>Last name</b> <b>DAVIS</b>		<b>2</b> Your social security number
Home address (number and street or rural route)		<b>3</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note.</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.		
City or town, state, and ZIP code		<b>4</b> If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► <input type="checkbox"/>		
<b>5</b> Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		<b>5</b> _____		
<b>6</b> Additional amount, if any, you want withheld from each paycheck		<b>6</b> \$ _____		
<b>7</b> I claim exemption from withholding for 2014, and I certify that I meet <b>both</b> of the following conditions for exemption. • Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability, <b>and</b> • This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability. If you meet both conditions, write "Exempt" here . . . . .		<b>7</b> _____		
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.				
<b>Employee's signature</b> (This form is not valid unless you sign it.) ►				
<b>8</b> Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		<b>9</b> Office code (optional)		<b>10</b> Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 10220Q

Form **W-4** (2014)



**Deductions and Adjustments Worksheet****Note.** Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

- 1 Enter an estimate of your 2014 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1950) of your income, and miscellaneous deductions. For 2014, you may have to reduce your itemized deductions if your income is over \$305,050 and you are married filing jointly or are a qualifying widow(er); \$279,650 if you are head of household; \$254,200 if you are single and not head of household or a qualifying widow(er); or \$152,525 if you are married filing separately. See Pub. 505 for details. 1 \$
- 2 Enter:  $\left\{ \begin{array}{l} \$12,400 \text{ if married filing jointly or qualifying widow(er)} \\ \$9,100 \text{ if head of household} \\ \$6,200 \text{ if single or married filing separately} \end{array} \right\}$  2 \$
- 3 Subtract line 2 from line 1. If zero or less, enter "-0-" 3 \$
- 4 Enter an estimate of your 2014 adjustments to income and any additional standard deduction (see Pub. 505) 4 \$
- 5 Add lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2014 Form W-4* worksheet in Pub. 505.) 5 \$
- 6 Enter an estimate of your 2014 nonwage income (such as dividends or interest) 6 \$
- 7 Subtract line 6 from line 5. If zero or less, enter "-0-" 7 \$
- 8 Divide the amount on line 7 by \$3,950 and enter the result here. Drop any fraction 8
- 9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 9
- 10 Add lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

**Two-Earners/Multiple Jobs Worksheet** (See *Two earners or multiple jobs* on page 1.)**Note.** Use this worksheet *only* if the instructions under line H on page 1 direct you here.

- 1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1
- 2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than "3" 2
- 3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3

**Note.** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

- 4 Enter the number from line 2 of this worksheet 4
- 5 Enter the number from line 1 of this worksheet 5
- 6 Subtract line 5 from line 4 6
- 7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here 7 \$
- 8 Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed 8 \$
- 9 Divide line 8 by the number of pay periods remaining in 2014. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2014. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$

**Table 1**

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$6,000	0	\$0 - \$6,000	0	\$0 - \$74,000	\$590	\$0 - \$37,000	\$590
6,001 - 13,000	1	6,001 - 16,000	1	74,001 - 130,000	990	37,001 - 80,000	990
13,001 - 24,000	2	16,001 - 25,000	2	130,001 - 200,000	1,110	80,001 - 175,000	1,110
24,001 - 26,000	3	25,001 - 34,000	3	200,001 - 355,000	1,300	175,001 - 385,000	1,300
26,001 - 33,000	4	34,001 - 43,000	4	355,001 - 400,000	1,380	385,001 and over	1,560
33,001 - 43,000	5	43,001 - 70,000	5	400,001 and over	1,560		
43,001 - 49,000	6	70,001 - 85,000	6				
49,001 - 60,000	7	85,001 - 110,000	7				
60,001 - 75,000	8	110,001 - 125,000	8				
75,001 - 80,000	9	125,001 - 140,000	9				
80,001 - 100,000	10	140,001 and over	10				
100,001 - 115,000	11						
115,001 - 130,000	12						
130,001 - 140,000	13						
140,001 - 150,000	14						
150,001 and over	15						

**Table 2**

**Privacy Act and Paperwork Reduction Act Notice.** We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.



Claim Number: 9452367

Form <b>W-4S</b> Department of the Treasury Internal Revenue Service	<b>Request for Federal Income Tax Withholding From Sick Pay</b> ▶ Give this form to the third-party payer of your sick pay. ▶ Information about Form W-4S is available at <a href="http://www.irs.gov/w4s">www.irs.gov/w4s</a> .		OMB No. 1545-0074 <b>2014</b>
	Type or print your first name and middle initial. <b>ARTHUR</b>	Last name <b>DAVIS</b>	Your social security number
Home address (number and street or rural route)			
City or town, state, and ZIP code			
Claim or identification number (if any)			
I request federal income tax withholding from my sick pay payments. I want the following amount to be withheld from each payment. (See <b>Worksheet</b> below.)			\$

Employee's signature ▶

Date ▶

----- Separate here and give the top part of this form to the payer. Keep the lower part for your records. -----

**Worksheet** (Keep for your records. Do not send to the Internal Revenue Service.)

1 Enter amount of adjusted gross income that you expect in 2014 . . . . .	1		
2 If you plan to itemize deductions on Schedule A (Form 1040), enter the estimated total of your deductions. For 2014, you may have to reduce your itemized deductions if your income is over \$305,050 and you are married filing jointly or are a qualifying widow(er); \$279,650 if you are head of household; \$254,200 if you are single and not head of household or a qualifying widow(er); or \$152,525 if you are married filing separately. See Pub. 505 for details. If you do not plan to itemize deductions, enter the standard deduction. (See the instructions on page 2 for the standard deduction amount, including additional amounts for age and blindness.) . . . . .	2		
3 Subtract line 2 from line 1 . . . . .	3		
4 Exemptions. Multiply \$3,950 by the number of personal exemptions . . . . .	4		
5 Subtract line 4 from line 3 . . . . .	5		
6 Tax. Figure your tax on line 5 by using the 2014 Tax Rate Schedule X, Y, or Z on page 2. Do not use the Tax Table or Tax Rate Schedule X, Y, or Z in the 2013 Form 1040, 1040A, or 1040EZ instructions . . . . .	6		
7 Credits (child tax and higher education credits, credit for child and dependent care expenses, etc.) . . . . .	7		
8 Subtract line 7 from line 6 . . . . .	8		
9 Estimated federal income tax withheld or to be withheld from other sources (including amounts withheld due to a prior Form W-4S) during 2014 or paid or to be paid with 2014 estimated tax payments . . . . .	9		
10 Subtract line 9 from line 8 . . . . .	10		
11 Enter the number of sick pay payments you expect to receive this year to which this Form W-4S will apply . . . . .	11		
12 Divide line 10 by line 11. Round to the nearest dollar. This is the amount that should be withheld from each sick pay payment. Be sure it meets the requirements for the amount that should be withheld, as explained under <i>Amount to be withheld</i> below. If it does, enter this amount on Form W-4S above . . . . .	12		

**General Instructions**

**Purpose of form.** Give this form to the third-party payer of your sick pay, such as an insurance company, if you want federal income tax withheld from the payments. You are not required to have federal income tax withheld from sick pay paid by a third party. However, if you choose to request such withholding, Internal Revenue Code sections 3402(o) and 6109 and their regulations require you to provide the information requested on this form. Do not use this form if your employer (or its agent) makes the payments because employers are already required to withhold federal income tax from sick pay.

**Note.** If you receive sick pay under a collective bargaining agreement, see your union representative or employer.

**Definition.** Sick pay is a payment that you receive:

- Under a plan to which your employer is a party and
- In place of wages for any period when you are temporarily absent from work because of your sickness or injury.

**Amount to be withheld.** Enter on this form the amount that you want withheld from each payment. The amount that you enter:

- Must be in whole dollars (for example, \$35, not \$34.50).
- Must be at least \$4 per day, \$20 per week, or \$88 per month based on your payroll period.

- Must not reduce the net amount of each sick pay payment that you receive to less than \$10.

For payments larger or smaller than a regular full payment of sick pay, the amount withheld will be in the same proportion as your regular withholding from sick pay. For example, if your regular full payment of \$100 a week normally has \$25 (25%) withheld, then \$20 (25%) will be withheld from a partial payment of \$80.

**Caution.** You may be subject to a penalty if your tax payments during the year are not at least 90% of the tax shown on your tax return. For exceptions and details, see Pub. 505, Tax Withholding and Estimated Tax. You may pay tax during the year through withholding or estimated tax payments or both. To avoid a penalty, make sure that you have enough tax withheld or make estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. You may estimate your federal income tax liability by using the worksheet above.

**Sign this form.** Form W-4S is not valid unless you sign it.

**Statement of income tax withheld.** After the end of the year, you will receive a Form W-2, Wage and Tax Statement, reporting the taxable sick pay paid and federal income tax withheld during the year. These amounts are reported to the Internal Revenue Service.

(continued on back)

For Paperwork Reduction Act Notice, see page 2.

Cat. No. 10226E

Form **W-4S** (2014)



**Changing your withholding.** Form W-4S remains in effect until you change or revoke it. You may do this by giving a new Form W-4S or a written notice to the payer of your sick pay. To revoke your previous Form W-4S, complete a new Form W-4S and write "Revoked" in the money amount box, sign it, and give it to the payer.

### Specific Instructions for Worksheet

You may use the worksheet on page 1 to estimate the amount of federal income tax that you want withheld from each sick pay payment. Use your tax return for last year and the worksheet as a basis for estimating your tax, tax credits, and withholding for this year.

You may not want to use Form W-4S if you already have your total tax covered by estimated tax payments or other withholding.

If you expect to file a joint return, be sure to include the income, deductions, credits, and payments of both yourself and your spouse in figuring the amount you want withheld.

**Caution.** If any of the amounts on the worksheet change after you give Form W-4S to the payer, you should use a new Form W-4S to request a change in the amount withheld.

### Line 2—Deductions

**Itemized deductions.** For 2014, you may have to reduce your itemized deductions if your income is over \$305,050 and you are married filing jointly or are a qualifying widow(er); \$279,650 if you are head of household; \$254,200 if you are single and not head of household or a qualifying widow(er); or \$152,525 if you are married filing separately. See Pub. 505 for details.

**Standard deduction.** For 2014, the standard deduction amounts are:

Filing Status	Standard Deduction
Married filing jointly or qualifying widow(er)	\$12,400*
Head of household	\$9,100*
Single or Married filing separately	\$6,200*

\*If you are age 65 or older or blind, add to the standard deduction amount the additional amount that applies to you as shown in the next

paragraph. If you can be claimed as a dependent on another person's return, see *Limited standard deduction for dependents*, later.

**Additional amount for the elderly or blind.** An additional standard deduction of \$1,200 is allowed for a married individual (filing jointly or separately) or qualifying widow(er) who is 65 or older or blind, \$2,400 if 65 or older and blind. If both spouses are 65 or older or blind, an additional \$2,400 is allowed on a joint return (\$2,400 on a separate return if you can claim an exemption for your spouse). If both spouses are 65 or older and blind, an additional \$4,800 is allowed on a joint return (\$4,800 on a separate return if you can claim an exemption for your spouse). An additional \$1,550 is allowed for an unmarried individual (single or head of household) who is 65 or older or blind, \$3,100 if 65 or older and blind.

**Limited standard deduction for dependents.** If you can be claimed as a dependent on another person's return, your standard deduction is the greater of (a) \$1,000 or (b) your earned income plus \$350 (up to the regular standard deduction for your filing status). If you are 65 or older or blind, see Pub. 505 for additional amounts that you may claim.

**Certain individuals not eligible for standard deduction.** For the following individuals, the standard deduction is zero.

- A married individual filing a separate return if either spouse itemizes deductions.
- A nonresident alien individual.
- An individual filing a return for a period of less than 12 months because of a change in his or her annual accounting period.

### Line 7—Credits

Include on this line any tax credits that you are entitled to claim, such as the child tax and higher education credits, credit for child and dependent care expenses, earned income credit, or credit for the elderly or the disabled.

### Line 9—Tax Withholding and Estimated Tax

Enter the federal income tax that you expect will be withheld this year on income other than sick pay and any payments made or to be made with 2014 estimated tax payments. Include any federal income tax already withheld or to be withheld from wages and pensions.

## 2014 Tax Rate Schedules

### Schedule X—Single

If line 5 is:	But not over—	The tax is:	of the amount over—
Over—			
\$0	\$9,075	\$0 + 10%	\$0
9,075	36,900	907.50 + 15%	9,075
36,900	89,350	5,081.25 + 25%	36,900
89,350	186,350	18,193.75 + 28%	89,350
186,350	405,100	45,353.75 + 33%	186,350
405,100	406,750	117,541.25 + 35%	405,100
406,750	and greater	118,118.75 + 39.6%	406,750

### Schedule Y-1—Married filing jointly or Qualifying widow(er)

If line 5 is:	But not over—	The tax is:	of the amount over—
Over—			
\$0	\$18,150	\$0 + 10%	\$0
18,150	73,800	1,815 + 15%	18,150
73,800	148,850	10,162.50 + 25%	73,800
148,850	226,850	28,925 + 28%	148,850
226,850	405,100	50,765 + 33%	226,850
405,100	457,600	109,587.50 + 35%	405,100
457,600	and greater	127,962.50 + 39.6%	457,600

### Schedule Z—Head of household

If line 5 is:	But not over—	The tax is:	of the amount over—
Over—			
\$0	\$12,950	\$0 + 10%	\$0
12,950	49,400	1,295 + 15%	12,950
49,400	127,550	6,762.50 + 25%	49,400
127,550	206,600	26,300 + 28%	127,550
206,600	405,100	48,434 + 33%	206,600
405,100	432,200	113,939 + 35%	405,100
432,200	and greater	123,424 + 39.6%	432,200

### Schedule Y-2—Married filing separately

If line 5 is:	But not over—	The tax is:	of the amount over—
Over—			
\$0	\$9,075	\$0 + 10%	\$0
9,075	36,900	907.50 + 15%	9,075
36,900	74,425	5,081.25 + 25%	36,900
74,425	113,425	14,462.50 + 28%	74,425
113,425	202,550	25,382.50 + 33%	113,425
202,550	228,800	54,793.75 + 35%	202,550
228,800	and greater	63,981.25 + 39.6%	228,800

**Paperwork Reduction Act Notice.** We ask for the information on this form to carry out the Internal Revenue laws of the United States.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax

returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.





# **aetna**® Reimbursement Agreement (LTD)

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company (Aetna) has contracted with my employer Dell Inc to administer the LTD plan under which I am a covered employee.

If my application for Long Term Disability ("LTD") benefits is approved, in consideration of the payment of LTD benefits without reduction on account of other benefit payments to which I or my eligible dependents may become entitled under the United States Social Security Act or from any of the other income sources described in the LTD plan, I hereby agree to reimburse Aetna, on behalf of the plan, for any and all overpayments made to me under the LTD plan or any short term disability plan provided by my employer. I understand that Aetna agrees to make payment in this manner in consideration of my agreement to promptly notify Aetna of the amounts and effective dates of any such benefits, and to promptly repay same. This reimbursement is applicable whether said amounts are paid by formal award, informal compromise, settlement, redemption agreement, or otherwise, regardless of the term used to describe such payment under applicable law. Further, I agree that any benefits due me, my beneficiaries, heirs, executors, administrators, or assigns under the LTD plan may be applied to any outstanding overpayment whether resulting from retroactive award of Social Security or any other income benefits as described in the LTD plan.

\_\_\_\_\_  
Signature of Employee/Authorized Representative

\_\_\_\_\_  
Social Security Number

Employee Gender ☐ Male ☐ Female

\_\_\_\_\_  
Date of Birth (MM/DD/YYYY):

\_\_\_\_\_  
Signature Date (MM/DD/YYYY)

Mail this completed form to:  
**Aetna Life Insurance Company**  
**PO Box 14560**  
**Lexington, KY 40512-4560**  
**Phone: 800-354-1779**  
**Fax: 1-866-667-1987**

**MI DT 48-008 ASC WKAB-Generic**  
GC-1587-5 (4-12)



# **aetna<sup>®</sup>** Reimbursement Agreement (LTD)

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company (Aetna) has issued to my employer, Dell Inc  
policy under which I am a covered employee.

the LTD

If my application for Long Term Disability ("LTD") benefits is approved, in consideration of the payment of LTD benefits without reduction on account of other benefit payments to which I or my eligible dependents may become entitled under the United States Social Security Act or from any of the other income sources described in the LTD policy, I hereby agree to reimburse Aetna for any and all overpayments made to me under the LTD policy or any short term disability plan provided by employer. I understand that Aetna agrees to make payment in this manner in consideration of my agreement to promptly notify Aetna of the amounts and effective dates of any such benefits, and to promptly repay same. This reimbursement is applicable whether said amounts are paid by formal award, informal compromise, settlement, redemption agreement, or otherwise, regardless of the term used to describe such payment under applicable law. Further, I agree that any benefits due me, my beneficiaries, heirs, executors, administrators or assigns under the LTD policy may be applied to any outstanding overpayment whether resulting from retroactive award of Social Security or any other income benefits as described in the LTD policy.

With respect to any group life insurance coverage provided me by Aetna and in consideration of the foregoing, I hereby assign to Aetna, as creditor beneficiary, an amount of such group life insurance equal to the amount of any overpayment which may be outstanding under the LTD policy at the time of death.

\_\_\_\_\_  
Signature of Employee/Authorized Representative

\_\_\_\_\_  
Social Security Number

Employee Gender ☐ Male ☐ Female

\_\_\_\_\_  
Date of Birth (MM/DD/YYYY):

\_\_\_\_\_  
Signature Date (MM/DD/YYYY)

Mail this completed form to:

**Aetna Life Insurance Company**  
**PO Box 14560**  
**Lexington, KY 40512-4560**  
**Phone: 800-354-1779**  
**Fax: 1-866-667-1987**

**MI DT 48-008 Insured WKAB-Generic**  
GC-1589-5 (4-12)









## WorkAbility® Absence Management System

A better way to keep track of your claim

The site is so easy to use. You can log in any time, day or night.

### [www.aetnadisability.com](http://www.aetnadisability.com)

You've created a claim with us because you need to be out of work. Now your focus is making sure the process goes smoothly so if your claim is approved, you get paid correctly and on time.

The Aetna WorkAbility® website can help!

#### **All you have to do is sign up on the site:**

- Go to [www.aetnadisability.com](http://www.aetnadisability.com)
- Click "Register Now"
- Follow the prompts to create your secure user ID and password

Here are some of the things you may be able to do:

- Print or download forms needed to process your claim
- Check the status of your claims and payments
- Get letters and updates as soon as possible by telling us to send them electronically instead of in the mail - then log in to read them
- Add time to a claim
- Print copies of your benefits pay stubs, or save them to your computer
- Sign up for direct deposit
- Report a return-to-work day so your employer knows when you'll be back
- Contact Aetna at any time via E-mail

(Your employer may not offer all of these options.)

Make it easy on yourself. Start using the WorkAbility® website today. Go to [www.aetnadisability.com](http://www.aetnadisability.com) and select "Register Now."

Aetna Mobile - Find what you need – wherever, whenever



Two ways to download your FREE Aetna Mobile App:

- Text Apps to 44040 to download now\*
- Scan the code with your mobile device

Learn more, visit us at [www.aetna.com/mobile](http://www.aetna.com/mobile)

\*Standard text messaging rates may apply







PO Box 14560  
Lexington, KY 40512-4560  
MARIBEL AMOR  
Senior LTD Disability Benefit Manager  
Phone: 800-354-1779  
Fax: 1-866-667-1987

02/14/2014

ARTHUR DAVIS

REDACTED

MURFREESBORO TN - 37128

Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim No: 9452367

Dear Mr. Davis:

This letter is regarding your Long Term Disability (LTD) claim filed under the Dell Inc group policy. As you have been notified, your LTD claim has been assigned for claim evaluation and your initial determination review is underway.

Aetna's goal is to make your LTD determination by your LTD claim effective date, which is the date benefits would begin if you meet your Plan's definition of disability, or within 45 days from the date we receive your LTD claim.

At this time, we are in need of the following outstanding information in order to complete our initial LTD claim determination. Please be advised, it is your responsibility to provide proof of your claim. Your failure to provide the information requested in this letter could result in an adverse decision of your claim. At this time, we are providing you with 30 days from the date of this letter to provide the outstanding information.

From You:

- Authorization for Release of Medical Information
- Reimbursement Agreement
- Other Income Questionnaire
- Authorization to Secure Social Security Information
- Authorization to Obtain Information
- Work History and Education Questionnaire
- W4-S
- Social Security Authorization

You may have received a copy of the above listed forms in our initial LTD claim acknowledgment letter. However, to date, we have not received your responses.  
Please contact your provider(s) immediately to request they complete the requested documents and to help facilitate our receipt of this requested information. You may provide your employer with a copy of this letter.  
Attach Your Attending Physician(s):

- An Attending Physician Statement from Dr. Renfro
- A Capabilities and Limitations Worksheet from Dr. Renfro

Please contact your provider(s) immediately and ask they please mail or fax the requested medical information to:

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Fax: 1-866-667-1987

We hope you understand the importance of this letter and the information requested herein. As noted above, it is your responsibility to provide proof of your LTD claim.

Upon receipt of the outstanding information, we will make every effort to complete your claim determination. If we do not receive the requested information by 03/14/2014, a decision may be made based on the information contained in your file at that time, which could result in an adverse decision of your claim or a delayed payment.

Thank you for your cooperation. We will continue to keep you updated on the status of your claim and will advise you if we require any additional information to complete our review.

If you have any questions, or for medical reasons you are not able to provide the above requested information, please contact our office immediately at 800-354-1779.

Sincerely,

MARIBEL AMOR  
Aetna Life Insurance Company

Enclosure(s):

Attaching "Provisional Determination"  
Indicates that the information provided is not  
sufficient to make a final decision. The decision will be made at a later date.

1

Claim Number: 9452367



# Attending Physician Statement

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

## 1. Patient Information

Name				Employer Name		Job Title	
Year of Birth	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No	Height (ft./in.)	Weight (lbs.)	BMI	Blood Pressure	Date Measured

## 2. Diagnostic Information

Primary Diagnosis	
ICD-9 Code(s)	DSM IV Code(s)
Complications	
Objective Findings	
Subjective Symptoms	
Are there any secondary conditions contributing to this conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what are they? _____	
Has this patient ever had the same condition or a similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what year(s)/describe? _____	

## 3. Treatment Information

Primary Diagnosis			First day recommended out of work
Date symptoms first appeared (or date of accident)	Date first treated for this condition	Most recent date treated for this condition	
Frequency with which you see this patient: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____ Provide date(s): _____			ICD9 code(s)
Has the patient undergone surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide date. / /	CPT code(s) & Procedure	Result
Do you expect surgery to be performed in the future? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide date. / /	Planned Procedure & CPT code	
Please list current medications with dosage and frequency.			
Please list other types and frequency of treatment.			
Is the patient a suitable candidate for vocational rehabilitation? <input type="checkbox"/> Yes <input type="checkbox"/> No		Please explain.	

## 4. Please list all treating or consulting physicians (include date of treatment as indicated).

a. Physician Name	Physician Telephone Number
Physician Address	Treatment Dates From: / / To: / /
b. Physician Name	Physician Telephone Number
Physician Address	Treatment Dates From: / / To: / /
c. Physician Name	Physician Telephone Number
Physician Full Address	Treatment Dates From: / / To: / /

WKAB

GR-68337 (7-13)



Patient Name	Year of Birth
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**5. Please indicate any hospital / medical rehabilitation confinement for this patient, for this condition (include dates of confinement as indicated).**

a. Hospital / Facility Name	
Hospital / Facility Full Address	Treatment Dates From: ____ / ____ / ____ To: ____ / ____ / ____
b. Hospital / Facility Name	
Hospital / Facility Full Address	Treatment Dates From: ____ / ____ / ____ To: ____ / ____ / ____

**6. Progress**

Patient Status	
<input type="checkbox"/> Recovered	<input type="checkbox"/> Improved
<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Home Bound
<input type="checkbox"/> Unchanged	<input type="checkbox"/> Retrogressed
<input type="checkbox"/> Bed Confined	<input type="checkbox"/> Hospitalized
What is the prognosis?	
Has the patient achieved Maximum Medical Improvement? If No, how soon do you expect fundamental changes in the patient's medical condition:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1-2 months <input type="checkbox"/> 5-6 months <input type="checkbox"/> 3-4 months <input type="checkbox"/> More than 6 months
Please note any restrictions (activities your patient should not do).	
Please note any limitations (activities your patient cannot).	
Please describe any physical and/or MENTAL impairments.	
Date patient released from your care (if applicable). ____ / ____ / ____	Date patient able to return to full duty. ____ / ____ / ____

**7. Level of Impairment**

Physical Impairment (if applicable):	Mental/Nervous Impairment (if applicable):
<input type="checkbox"/> Class 1. No limitation of functional capacity/capable of heavy work.	<input type="checkbox"/> No Limitation: able to function under stress and engage in interpersonal relationships.
<input type="checkbox"/> Class 2. Slight limitation of functional capacity/capable of medium manual work	<input type="checkbox"/> Slight limitation: able to function in most stress situations and engage in most interpersonal relationships
<input type="checkbox"/> Class 3. Moderate limitation of functional capacity/capable of light work.	<input type="checkbox"/> Moderate limitation: able to engage in only limited stress and limited interpersonal relationships.
<input type="checkbox"/> Class 4. Marked limitation of functional capacity/capable of sedentary work.	<input type="checkbox"/> Marked limitation: unable to engage in stress or interpersonal relationships.
<input type="checkbox"/> Class 5. Severe limitation of functional capacity/incapable of sedentary work.	<input type="checkbox"/> Severe limitation: has significant loss of psychological, physiological, personal and social adjustment.
Cardiac Functional Capacity – NY Heart Association:	
<input type="checkbox"/> Class 1. No limitation <input type="checkbox"/> Class 2. Slight limitation <input type="checkbox"/> Class 3. Moderate limitation <input type="checkbox"/> Class 4. Complete limitation	
Do you believe your patient is competent to endorse checks and direct the use of the proceeds thereof?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Comments/Information	

**8. Attending Physician Information**

Physician's Signature	Date (MM/DD/YYYY) ____ / ____ / ____
Physician Name: _____	Specialty: _____
Phone Number: _____	Fax Number: _____
Address: _____	

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

WKAB- GR-68337 (7-13)



Claim Number: 9452367

Patient Name	Year of Birth
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#### 9. Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

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GR-68337 (7-13)

Page 2



Claim Number: 9452367



# Capabilities and Limitations Worksheet

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

Employee Name (Last, First, Middle Initial) <b>DAVIS, ARTHUR</b>		Social Security Number	Year of Birth																																		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Job Title		Control Number <b>0476626</b>																																		
Current Diagnosis		Medications:																																			
<p>Indicate the percent of the day the following activities can be performed: (<b>O</b>ccasional 1-33% or .5-2.5 hrs. <b>F</b>requent 34-66% or 2.6-5.0 hrs. <b>C</b>ontinuous 67-100% or 5.1-8 hrs. or <b>N</b>ever)</p> <table style="width:100%;"> <tr> <td style="width:50%; vertical-align: top;"> <div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div> </td> <td style="width:50%; vertical-align: top;"> <div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div> </td> </tr> <tr> <td style="vertical-align: top;"> Climbing - Crawling Kneeling Lifting Pulling Pushing Reaching above shoulder Forward reaching Carrying Bending Twisting </td> <td style="vertical-align: top;"> Hand Grasping __R__L Firm Hand Grasping __R__L Fine Manipulation __R__L Gross Manipulation __R__L Repetitive Motion __R__L Sitting __R__L Standing __R__L Stooping __R__L Walking __R__L Other _____ </td> </tr> </table>				<div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>	<div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>	Climbing - Crawling Kneeling Lifting Pulling Pushing Reaching above shoulder Forward reaching Carrying Bending Twisting	Hand Grasping __R__L Firm Hand Grasping __R__L Fine Manipulation __R__L Gross Manipulation __R__L Repetitive Motion __R__L Sitting __R__L Standing __R__L Stooping __R__L Walking __R__L Other _____																														
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Maximum weight patient is capable of lifting: <table style="width:100%;"> <tr><td style="width:50%;"></td><td style="width:50%; text-align: center;"><b>O</b> <b>F</b> <b>C</b> <b>N</b></td></tr> <tr><td>1 - 5 lbs.</td><td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td></tr> <tr><td>6 - 10 lbs.</td><td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td></tr> <tr><td>11 - 20 lbs.</td><td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td></tr> <tr><td>21 - 35 lbs.</td><td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td></tr> <tr><td>36 - 50 lbs.</td><td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td></tr> <tr><td>51 - 75 lbs.</td><td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td></tr> <tr><td>75 - 100 lbs.</td><td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td></tr> <tr><td>100 lbs. +</td><td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td></tr> </table>			<b>O</b> <b>F</b> <b>C</b> <b>N</b>	1 - 5 lbs.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	6 - 10 lbs.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	11 - 20 lbs.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	21 - 35 lbs.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	36 - 50 lbs.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	51 - 75 lbs.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	75 - 100 lbs.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	100 lbs. +	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Approved Head and Neck Movements: <table style="width:100%;"> <tr><td style="width:50%;"></td><td style="width:50%; text-align: center;">Yes No</td></tr> <tr><td>Static Position</td><td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/></td></tr> <tr><td>Frequent Flexing</td><td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/></td></tr> <tr><td>Frequent Rotation</td><td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/></td></tr> </table> Can the Patient operate: <table style="width:100%;"> <tr><td style="width:50%;"></td><td style="width:50%; text-align: center;">Yes No</td></tr> <tr><td>A Motor Vehicle</td><td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/></td></tr> <tr><td>Hazardous Machine</td><td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/></td></tr> <tr><td>Power Tools</td><td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/></td></tr> </table>			Yes No	Static Position	<input type="checkbox"/> <input type="checkbox"/>	Frequent Flexing	<input type="checkbox"/> <input type="checkbox"/>	Frequent Rotation	<input type="checkbox"/> <input type="checkbox"/>		Yes No	A Motor Vehicle	<input type="checkbox"/> <input type="checkbox"/>	Hazardous Machine	<input type="checkbox"/> <input type="checkbox"/>	Power Tools	<input type="checkbox"/> <input type="checkbox"/>
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Total # of hours patient capable of working per day: 12 <input type="checkbox"/> 8 <input type="checkbox"/> 6 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> Duration of restrictions: _____ Care Complete: Yes <input type="checkbox"/> No <input type="checkbox"/> Next Appointment: _____ Additional Comments: _____ _____ _____																																					
Physician's Signature			Date (MM/DD/YYYY)																																		
Physician Name		Specialty																																			
Phone Number		Fax Number																																			
Address																																					

WKAB  
GC-1500-26 (7-13)

Page 1 of 2





Claim Number: 9452367

Employee Name (Last, First Middle Initial) Required  
DAVIS, ARTHUR

### Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Employee's Signature

Date (MM/DD/YYYY)



**Instructions for Using this Form**

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

**NOTE:** Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at [www.ssa.gov/online/ssa-7050.pdf](http://www.ssa.gov/online/ssa-7050.pdf).

**How to Complete this Form**

We will not honor this form unless all required fields are completed. An asterisk (\*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- You, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

**PRIVACY ACT STATEMENT**

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3. To comply with Federal laws requiring the disclosure of the information from our records; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, [www.socialsecurity.gov](http://www.socialsecurity.gov), or at your local Social Security office.

**PAPERWORK REDUCTION ACT STATEMENT**

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at [www.socialsecurity.gov](http://www.socialsecurity.gov). Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

Form SSA-3288 (07-2013) EF (07-2013) Destroy Prior Editions



Social Security Administration  
Consent for Release of Information

Form Approved  
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. (\*signifies a required field).

**TO: Social Security Administration**

ARTHUR DAVIS

REDACTED

**\*My Full Name**

**\*My Date of Birth**  
(MM/DD/YYYY)

**\*My Social Security Num**

I authorize the Social Security Administration to release information or records about me to:

**\*NAME OF PERSON OR ORGANIZATION:**

**\*ADDRESS OF PERSON OR ORGANIZATIO**

PO Box 14560

Lexington, KY 40512-4560

**\*I want this information released because:**

We may charge a fee to release information for non-program purposes.

**\*Please release the following information selected from the list below:**

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1. ☐ Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date \_\_\_\_\_ to date \_\_\_\_\_
5. ☐ My Medicare entitlement from date \_\_\_\_\_ to date \_\_\_\_\_
6. ☐ Medical records from my claims folder(s) from date \_\_\_\_\_ to date \_\_\_\_\_  
If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file (you must specify the records you are requesting, e.g., doctor report, applicati  
determination or questionnaire)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004)) that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to \$5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

**\*Signature:** \_\_\_\_\_ **\*Date:** \_\_\_\_\_

**\*Address:** \_\_\_\_\_

**Relationship (if not the individual):** \_\_\_\_\_

**\*Daytime Phone:** \_\_\_\_\_

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signature who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of witness: \_\_\_\_\_ 2. Signature of witness : \_\_\_\_\_

Address: \_\_\_\_\_  
(Number and street, City, State, and Zip Code)

Address: \_\_\_\_\_  
(Number and street, City, State, and Zip Code)

Form SSA-3288 (07-2013) EF (07-2013)





PO Box 14560  
Lexington, KY 40512-4560  
MARIBEL AMOR  
Senior LTD Disability Benefit Manager  
Phone: 800-354-1779  
Fax: 1-866-667-1987

04/03/2014

ARTHUR DAVIS

REDACTED

MURFREESBORO TN - 37128

Group Control No: 0476626  
Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

Dear Mr. Davis:

The Dell Inc group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna).

We are writing to update you on the status of our evaluation of your entitlement to Long Term Disability (LTD) benefits.

Our standard is to review and determine your claim by the claim effective date which is 04/07/2014.

Your plan's definition of disability is as follows:

Test of Disability

From the date that you first became disabled and until monthly benefits are payable for 24 months you meet the test of disability on any day that:

- . You cannot perform the material duties of your own occupation solely because of an illness, injury or disabling pregnancy-related condition and;
- . Your earnings are 80% or less of your adjusted pre-disability earnings.

After the first 24 months of your disability that monthly benefits are payable, you meet the plan's test of disability on any day you are unable to work at any reasonable occupation solely because of an illness, injury or disabling pregnancy-related condition.

The loss of a professional or occupational license or certification that is required by your own occupation does not mean you meet the test of disability. You must meet the plan's test of disability to be considered disabled.

We have submitted your file for a peer to peer consultation and review of the medical records.

We need this information to determine if you meet the definition of disability described above. It will let us know how your medical condition imposes limitations upon your ability to perform your work duties, the essential functions of your own occupation, the material duties of your job.

We have not been able to complete our review by your claim effective date. As such, we require a 30 day extension to complete our review of your claim and make a determination. We expect to be able to make a decision on your claim no later than May 6, 2014.

Thank you for your continued cooperation and patience during the review of your claim for benefits. If you have any questions, please feel free to contact me at 800-354-1779 .

Sincerely,

MARIBEL AMOR  
Senior LTD Disability Benefit Manager  
Aetna Life Insurance Company



PO Box 14560  
Lexington, KY 40512-4560  
800-354-1779

---

**Facsimile Transmittal Sheet**

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To:		From:
Dr. Cote		MARIBEL AMOR
Employer:		Date:
Dell Inc		02/17/2014
Fax Number:		CLAIM NUMBER:
615-895-6212		9452367
Phone number:		Sender's Phone Number:
		800-354-1779
		Sender's FAX Number:
		1-866-667-1987
Re: MR. ARTHUR DAVIS		Total No. of Pages Including Cover:
Date of Birth: REDACTED		

Urgent    For Review    Please Comment    xx Please Reply    Please Recycle

Dear Dr. Cote:

Please complete the attached form and provide us with the progress notes for the last three (3) months of treatment. Thanks, Maribel

Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you received this communication in error, please notify the sender at the phone number above.

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---

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Enclosed:

Attending Physician Statement

Claim Number: 9452367



# **Attending Physician Statement – Musculoskeletal: Orthopaedic Surgery, Spinal Surgery, Physiatry, Podiatry, Chiro**

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

**1. Patient Information**

Name				Employer Name		Job Title	
Year of Birth	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No	Height (ft./in.)	Weight (lbs.)	BMI	Blood Pressure	Date Measured

**2. Physician Information**

Name		Specialty
Tax I.D. Number	Telephone Number (include area code)	Fax Number (include area code)

**3. Management Information**

Disability Benefits Manager <b>MARIBEL AMOR</b>	Telephone Number (include area code) <b>800-354-1779</b>	Fax Number (include area code) <b>1-866-667-1987</b>
--	---	---

**4. Treatment Information**

First Day recommended out of Work	Initial Treatment Date	Last Appointment Date	Surgery Date
Medication (Name, Dosage and Frequency)			
Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Hospitalization Admitted on ____ / ____ / ____ Discharged on ____ / ____ / ____	Recent Surgery Date (MM/DD/YYYY) ____ / ____ / ____	

**5. Clinical Condition**

Diagnosis	ICD9 Code(s)	Procedure (if applicable)	CPT Code(s)
Is this condition responsible for any functional impairment?		<input type="checkbox"/> Yes, complete <b>Sections 6, 7, 8 and 9</b> <input type="checkbox"/> No, provide a release to full duty in <b>Section 9</b>	
Is the condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Date of Injury / Illness ____ / ____ / ____	

**6. Treatment Plan**

Facility Name		Telephone Number (include area code)
Address (Include Zip Code)		

**7. Objective Data that documents a functional impairment**

Please record vital signs and describe physical exam (Quantitative ROM, Gait, Motor/Sensory/DTR, Neuro Findings, Effusions, Girth of Extremities) or WNL
Diagnostic Tests (X-Rays, CT / MRI, Myelogram, Discogram, Arthrogram, EMG/NCV, Bone Scans, Lab Test, etc.) or WNL
Other (PT/OT status, Pre & Post Surgical Indications and/or complications) or WNL

**8. Work Restrictions**

--

**9. Return to Work Status**

<input type="checkbox"/> Able to return to full duty on (date): ____ / ____ / ____
<input type="checkbox"/> Able to work with restrictions. Can return to work on (date): ____ / ____ / ____ Work restrictions will apply until (date): ____ / ____ / ____
<input type="checkbox"/> I am unable to release this patient. I anticipate significant clinical improvement by date: ____ / ____ / ____ Next appointment (date): ____ / ____ / ____

**10. Signature**

Physician's Signature	Date (MM/DD/YYYY) ____ / ____ / ____
Physician Name: _____	Specialty: _____
Phone Number: _____	Fax Number: _____
Address: _____	

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

WKAB- GR-68332 (7-13)



Claim Number: 9452367

Patient Name	Year of Birth
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#### 11. Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

WKAB  
GR-68332 (7-13)

Page 2







PO Box 14560  
Lexington, KY 40512-4560  
800-354-1779

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**Facsimile Transmittal Sheet**

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To:		From:
Murfreesboro Results Physiotherapy		MARIBEL AMOR
Employer:		Date:
Dell Inc		02/17/2014
Fax Number:		CLAIM NUMBER:
615-896-6825		9452367
Phone number:		Sender's Phone Number:
615-896-6825		800-354-1779
		Sender's FAX Number:
		1-866-667-1987
Re: MR. ARTHUR DAVIS		Total No. of Pages Including Cover:
Date of Birth: REDACTED		

Urgent   For Review   Please Comment   xx Please Reply   Please Recycle

Mr. Davis is being reviewed for eligibility to receive LTD benefits. Please submit the progress notes and evaluations for the last three months of treatment. Thanks, Maribel

Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

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Enclosed:



PO Box 14560  
Lexington, KY 40512-4560  
800-354-1779

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**Facsimile Transmittal Sheet**

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To:		From:
Dr. Nicholas Cote		MARIBEL AMOR
Employer:		Date:
Dell Inc		02/26/2014
Fax Number:		CLAIM NUMBER:
615-895-6212		9452367
Phone number:		Sender's Phone Number:
		800-354-1779
		Sender's FAX Number:
		1-866-667-1987
Re: MR. ARTHUR DAVIS		Total No. of Pages Including Cover:
Date of Birth: REDACTED		

Urgent    For Review    Please Comment    xx Please Reply    Please Recycle

Dear Dr. Cote:

We are reviewing your patient's claim for eligibility to receive LTD benefits. Please complete the attached form and provide us with the progress notes for the last three (3) months of treatment. Thanks, Maribel

Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

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Enclosed:  
Attending Physician Statement

Claim Number: 9452367



**Attending Physician Statement –  
Musculoskeletal: Orthopaedic Surgery,  
Spinal Surgery, Physiatry, Podiatry, Chiro**

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

**1. Patient Information**

Name				Employer Name		Job Title	
Year of Birth	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No	Height (ft./in.)	Weight (lbs.)	BMI	Blood Pressure	Date Measured

**2. Physician Information**

Name		Specialty
Tax I.D. Number	Telephone Number (include area code)	
		Fax Number (include area code)

**3. Management Information**

Disability Benefits Manager <b>MARIBEL AMOR</b>	Telephone Number (include area code) <b>800-354-1779</b>	Fax Number (include area code) <b>1-866-667-1987</b>
--	---	---

**4. Treatment Information**

First Day recommended out of Work	Initial Treatment Date	Last Appointment Date	Surgery Date
Medication (Name, Dosage and Frequency)			
Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Hospitalization Admitted on ____ / ____ / ____ Discharged on ____ / ____ / ____		Recent Surgery Date (MM/DD/YYYY) ____ / ____ / ____

**5. Clinical Condition**

Diagnosis	ICD9 Code(s)	Procedure (if applicable)	CPT Code(s)
Is this condition responsible for any functional impairment?		<input type="checkbox"/> Yes, complete <b>Sections 6, 7, 8 and 9</b> <input type="checkbox"/> No, provide a release to full duty in <b>Section 9</b>	
Is the condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Date of Injury / Illness ____ / ____ / ____	

**6. Treatment Plan**

Facility Name		Telephone Number (include area code)
Address (Include Zip Code)		

**7. Objective Data that documents a functional impairment**

Please record vital signs and describe physical exam (Quantitative ROM, Gait, Motor/Sensory/DTR, Neuro Findings, Effusions, Girth of Extremities) or WNL
Diagnostic Tests (X-Rays, CT / MRI, Myelogram, Discogram, Arthrogram, EMG/NCV, Bone Scans, Lab Test, etc.) or WNL
Other (PT/OT status, Pre & Post Surgical Indications and/or complications) or WNL

**8. Work Restrictions**

--

**9. Return to Work Status**

<input type="checkbox"/> Able to return to full duty on (date): ____ / ____ / ____
<input type="checkbox"/> Able to work with restrictions. Can return to work on (date): ____ / ____ / ____ Work restrictions will apply until (date): ____ / ____ / ____
<input type="checkbox"/> I am unable to release this patient. I anticipate significant clinical improvement by date: ____ / ____ / ____ Next appointment (date): ____ / ____ / ____

**10. Signature**

Physician's Signature	Date (MM/DD/YYYY) ____ / ____ / ____
Physician Name: _____	Specialty: _____
Phone Number: _____	Fax Number: _____
Address: _____	

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

WKAB- GR-68332 (7-13)



Claim Number: 9452367

Patient Name	Year of Birth
--------------	---------------

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WKAB  
GR-68332 (7-13)

Page 2





PO Box 14560  
Lexington, KY 40512-4560  
800-354-1779

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**Facsimile Transmittal Sheet**

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To:		From:
Dr. Renfro		MARIBEL AMOR
Employer:		Date:
Dell Inc		02/26/2014
Fax Number:		CLAIM NUMBER:
615-834-4722		9452367
Phone number:		Sender's Phone Number:
		800-354-1779
		Sender's FAX Number:
		1-866-667-1987
Re: MR. ARTHUR DAVIS		Total No. of Pages Including Cover:
Date of Birth: REDACTED		

☐ Urgent    ☐ For Review    ☐ Please Comment    ☒ Please Reply    ☐ Please Recycle

Dear Dr. Renfro:

Please complete the attached form and provide us with all the progress notes, evaluations for February 2014.  
Thanks, Maribel

Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

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---

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Enclosed:

Attending Physician Statement

Claim Number: 9452367



# **Attending Physician Statement – Musculoskeletal: Orthopaedic Surgery, Spinal Surgery, Physiatry, Podiatry, Chiro**

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

**1. Patient Information**

Name				Employer Name		Job Title	
Year of Birth	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No	Height (ft./in.)	Weight (lbs.)	BMI	Blood Pressure	Date Measured

**2. Physician Information**

Name		Specialty
Tax I.D. Number	Telephone Number (include area code)	
		Fax Number (include area code)

**3. Management Information**

Disability Benefits Manager <b>MARIBEL AMOR</b>	Telephone Number (include area code) <b>800-354-1779</b>	Fax Number (include area code) <b>1-866-667-1987</b>
--	---	---

**4. Treatment Information**

First Day recommended out of Work	Initial Treatment Date	Last Appointment Date	Surgery Date
Medication (Name, Dosage and Frequency)			
Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Hospitalization Admitted on ____ / ____ / ____ Discharged on ____ / ____ / ____		Recent Surgery Date (MM/DD/YYYY) ____ / ____ / ____

**5. Clinical Condition**

Diagnosis	ICD9 Code(s)	Procedure (if applicable)	CPT Code(s)
Is this condition responsible for any functional impairment?		<input type="checkbox"/> Yes, complete <b>Sections 6, 7, 8 and 9</b> <input type="checkbox"/> No, provide a release to full duty in <b>Section 9</b>	
Is the condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Date of Injury / Illness ____ / ____ / ____	

**6. Treatment Plan**

Facility Name		Telephone Number (include area code)
Address (Include Zip Code)		

**7. Objective Data that documents a functional impairment**

Please record vital signs and describe physical exam (Quantitative ROM, Gait, Motor/Sensory/DTR, Neuro Findings, Effusions, Girth of Extremities) or WNL
Diagnostic Tests (X-Rays, CT / MRI, Myelogram, Discogram, Arthrogram, EMG/NCV, Bone Scans, Lab Test, etc.) or WNL
Other (PT/OT status, Pre & Post Surgical Indications and/or complications) or WNL

**8. Work Restrictions**

--

**9. Return to Work Status**

<input type="checkbox"/> Able to return to full duty on (date): ____ / ____ / ____
<input type="checkbox"/> Able to work with restrictions. Can return to work on (date): ____ / ____ / ____ Work restrictions will apply until (date): ____ / ____ / ____
<input type="checkbox"/> I am unable to release this patient. I anticipate significant clinical improvement by date: ____ / ____ / ____ Next appointment (date): ____ / ____ / ____

**10. Signature**

Physician's Signature	Date (MM/DD/YYYY) ____ / ____ / ____
Physician Name: _____	Specialty: _____
Phone Number: _____	Fax Number: _____
Address: _____	

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WKAB- GR-68332 (7-13)



Claim Number: 9452367

Patient Name	Year of Birth
--------------	---------------

#### 11. Misrepresentation

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WKAB  
GR-68332 (7-13)

Page 2



Claim Number: 9452367

# aetna

## Authorization For Aetna To Request Protected Health Information Necessary To Process A Disability Claim

Please Read The Following Carefully Before Completing Your Authorization. You May Refuse To Sign This Authorization. (See Section 6.)

### 1. Member Information (Information About Person For Whom This Authorization Is Requested.)

Last Name DAVIS	First Name ARTHUR	Middle Initial C
Claim Number 9452367	Year of Birth REDACTED	Daytime Telephone Number (include area code) REDACTED
Street Address REDACTED	City, State and ZIP Murfreesboro, TN 37128	

2. This form requests a Member's unconditioned authorization for Aetna to ask another person or organization to disclose Member's Protected Health Information ("PHI") to Aetna for the purpose of processing my disability claim.

### 3. The specific PHI we are asking you to authorize Aetna to request is (This section completed by Aetna.)

Any and all medical information including but not limited to information which relates to psychiatric or mental health, drug, substance abuse, and/or HIV Infection, including AIDS and related illnesses, concerning health care, advice and treatment and prescription history records (including but not limited to, medical records, histories, physical or diagnostic examinations reports and treatment notes).

### 4. If you prefer to authorize the request of only selected categories of information, please indicate below which types of information may be disclosed. (This section completed by Member)

<input type="checkbox"/> Health (This includes medical, dental, pharmacy, vision, and flexible spending account information)
<input type="checkbox"/> Behavioral Health (e.g., mental health, drug and alcohol abuse treatment)
<input type="checkbox"/> Disability <input type="checkbox"/> Life Insurance <input type="checkbox"/> Long Term Care <input type="checkbox"/> Workers' Compensation
<input type="checkbox"/> Other: (please specify) _____

### 5. By signing this form, you will authorize Aetna to request PHI described above from the following persons or organizations (or classes of persons or organizations.)

Service Providers, including but not limited, to physicians, therapists, medical practitioners, health care professionals, workers' compensation professionals, diagnostic facilities, hospitals, clinics and pharmacy related service organizations (including individuals or facilities which provide rehabilitation services or treatment).

### 6. Expiration of this Authorization

This authorization is valid throughout the processing and any term of your disability claim unless you indicate a shorter period below.

mm/dd/yyyy	through	mm/dd/yyyy
------------	---------	------------

Please review and complete important information on the reverse of this form.

WKAB  
GR-67940-26 (6-13) D

Page 1 of 3  
R-POD



3225148884

DCN: 140220058745 PAGE: 019 SEQUENCE: 0220140004



Claim Number: 9452367

Employee Name  
ARTHUR DAVIS

**7. Important: Your signature below means that you understand and agree to the following:**

- You authorize Aetna to request from the persons or organizations named above, the PHI described above, for the purposes stated above.
- The information to be disclosed may be protected by law. Information disclosed under this authorization may be re-disclosed and no longer protected by federal privacy regulations.
- Failure to complete this form may prevent Aetna from receiving information necessary for the processing of your disability claim, which may result in a disability claim denial. Failure to complete this form will not however impact your receipt of medical services from providers.
- You may revoke this Authorization at any time by notifying Aetna in writing, but please note that actions Aetna has taken before we received your revocation will still be valid under this authorization.
- You may receive a copy of this form if you request it in writing from the address listed below.

**8. Signature of Member or Legal Representative**

Signature of Member or Legal Representative <i>Arthur C Davis, Jr.</i>	Date 02/11/2014
Print Name Arthur C Davis, Jr.	

If not the Member, describe your relationship to the Member:

- ☐ Caregiver  
☐ Legal Representative  
☐ Other: \_\_\_\_\_

If Member's legal representative is signing this Authorization, you must furnish a copy of the health care power of attorney, or other relevant document designating you as the representative.

**NOTICE TO RECIPIENT(S) OF INFORMATION (Section 2. above):**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

Return this completed form to: **Aetna Life Insurance Company**  
PO Box 14560  
Lexington, KY 40512-4560

Telephone Number: 800-354-1779  
Fax Number: 1-866-667-1987

WKAB  
GR-67940-26 (8-13) D

Page 2 of 3



0220140004

DCN: 140220058745 PAGE: 021 SEQUENCE: 0220140004

Claim Number: 9452367

Employee Name

DAVIS, ARTHUR

#### 9. Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

WKAB  
GR-67940-26 (8-13)

Page 3 of 3



0220140004

DCN: 140220058745 PAGE: 023 SEQUENCE: 0220140004

[[EMAILSUBJECT: Response to your query]]RE: Records needed

Dell Inc  
03/06/2014

Dear Mr. Davis:

We have requested Dr. Cote's medical records and the completion of forms but we have not received a response. Please have Dr. Cote complete the attached forms and submit all the available medical records from Dr. Cote. Thanks, Maribe

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>  
Attending Physician Statement  
Capabilities and Limitations Worksheet

Claim Number: 9452367



# **Attending Physician Statement – Musculoskeletal: Orthopaedic Surgery, Spinal Surgery, Physiatry, Podiatry, Chiro**

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

**1. Patient Information**

Name				Employer Name		Job Title	
Year of Birth	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No	Height (ft./in.)	Weight (lbs.)	BMI	Blood Pressure	Date Measured

**2. Physician Information**

Name		Specialty
Tax I.D. Number	Telephone Number (include area code)	Fax Number (include area code)

**3. Management Information**

Disability Benefits Manager <b>MARIBEL AMOR</b>	Telephone Number (include area code) <b>800-354-1779</b>	Fax Number (include area code) <b>1-866-667-1987</b>
--	---	---

**4. Treatment Information**

First Day recommended out of Work	Initial Treatment Date	Last Appointment Date	Surgery Date
Medication (Name, Dosage and Frequency)			
Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Hospitalization Admitted on ____ / ____ / ____ Discharged on ____ / ____ / ____	Recent Surgery Date (MM/DD/YYYY) ____ / ____ / ____	

**5. Clinical Condition**

Diagnosis	ICD9 Code(s)	Procedure (if applicable)	CPT Code(s)
Is this condition responsible for any functional impairment?		<input type="checkbox"/> Yes, complete <b>Sections 6, 7, 8 and 9</b> <input type="checkbox"/> No, provide a release to full duty in <b>Section 9</b>	
Is the condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Date of Injury / Illness ____ / ____ / ____	

**6. Treatment Plan**

Facility Name		Telephone Number (include area code)
Address (Include Zip Code)		

**7. Objective Data that documents a functional impairment**

Please record vital signs and describe physical exam (Quantitative ROM, Gait, Motor/Sensory/DTR, Neuro Findings, Effusions, Girth of Extremities) or WNL
Diagnostic Tests (X-Rays, CT / MRI, Myelogram, Discogram, Arthrogram, EMG/NCV, Bone Scans, Lab Test, etc.) or WNL
Other (PT/OT status, Pre & Post Surgical Indications and/or complications) or WNL

**8. Work Restrictions**

--

**9. Return to Work Status**

<input type="checkbox"/> Able to return to full duty on (date): ____ / ____ / ____
<input type="checkbox"/> Able to work with restrictions. Can return to work on (date): ____ / ____ / ____ Work restrictions will apply until (date): ____ / ____ / ____
<input type="checkbox"/> I am unable to release this patient. I anticipate significant clinical improvement by date: ____ / ____ / ____ Next appointment (date): ____ / ____ / ____

**10. Signature**

Physician's Signature	Date (MM/DD/YYYY) ____ / ____ / ____
Physician Name: _____	Specialty: _____
Phone Number: _____	Fax Number: _____
Address: _____	

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

WKAB- GR-68332 (7-13)



Claim Number: 9452367

Patient Name	Year of Birth
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#### 11. Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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WKAB  
GR-68332 (7-13)

Page 2



Claim Number: 9452367



# Capabilities and Limitations Worksheet

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

Employee Name (Last, First, Middle Initial) <b>DAVIS, ARTHUR</b>		Social Security Number	Year of Birth				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Job Title		Control Number <b>0476626</b>				
Current Diagnosis		Medications:					
<p>Indicate the percent of the day the following activities can be performed: (<b>O</b>ccasional 1-33% or .5-2.5 hrs. <b>F</b>requent 34-66% or 2.6-5.0 hrs. <b>C</b>ontinuous 67-100% or 5.1-8 hrs. or <b>N</b>ever)</p> <table style="width:100%;"> <tr> <td style="width:50%; vertical-align: top;"> <div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div> </td> <td style="width:50%; vertical-align: top;"> <div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div> </td> </tr> <tr> <td style="vertical-align: top;"> Climbing - Crawling Kneeling Lifting Pulling Pushing Reaching above shoulder Forward reaching Carrying Bending Twisting </td> <td style="vertical-align: top;"> Hand Grasping __R__L Firm Hand Grasping __R__L Fine Manipulation __R__L Gross Manipulation __R__L Repetitive Motion __R__L Sitting __R__L Standing __R__L Stooping __R__L Walking __R__L Other _____ </td> </tr> </table>				<div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>	<div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>	Climbing - Crawling Kneeling Lifting Pulling Pushing Reaching above shoulder Forward reaching Carrying Bending Twisting	Hand Grasping __R__L Firm Hand Grasping __R__L Fine Manipulation __R__L Gross Manipulation __R__L Repetitive Motion __R__L Sitting __R__L Standing __R__L Stooping __R__L Walking __R__L Other _____
<div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>	<div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>						
Climbing - Crawling Kneeling Lifting Pulling Pushing Reaching above shoulder Forward reaching Carrying Bending Twisting	Hand Grasping __R__L Firm Hand Grasping __R__L Fine Manipulation __R__L Gross Manipulation __R__L Repetitive Motion __R__L Sitting __R__L Standing __R__L Stooping __R__L Walking __R__L Other _____						
Maximum weight patient is capable of lifting: <div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>		Approved Head and Neck Movements: <div style="display: flex; justify-content: space-between;"><div><b>Yes</b></div><div><b>No</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>					
1 - 5 lbs. 6 - 10 lbs. 11 - 20 lbs. 21 - 35 lbs. 36 - 50 lbs. 51 - 75 lbs. 75 - 100 lbs. 100 lbs. +		Can the Patient operate: <div style="display: flex; justify-content: space-between;"><div><b>Yes</b></div><div><b>No</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>					
Limitations to: Speaking _____ hrs. Vision (explain) _____ Depth Perception _____ Hearing (explain) _____		Exposure Limitations: Yes No Heat <input type="checkbox"/> <input type="checkbox"/> Dust <input type="checkbox"/> <input type="checkbox"/> Cold <input type="checkbox"/> <input type="checkbox"/> Fumes <input type="checkbox"/> <input type="checkbox"/> Dampness <input type="checkbox"/> <input type="checkbox"/> Chemicals <input type="checkbox"/> <input type="checkbox"/> Noise <input type="checkbox"/> <input type="checkbox"/> Radiation <input type="checkbox"/> <input type="checkbox"/>					
Total # of hours patient capable of working per day: 12 <input type="checkbox"/> 8 <input type="checkbox"/> 6 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> Duration of restrictions: _____ Care Complete: Yes <input type="checkbox"/> No <input type="checkbox"/> Next Appointment: _____ Additional Comments: _____ _____ _____							
Physician's Signature			Date (MM/DD/YYYY)				
Physician Name		Specialty					
Phone Number		Fax Number					
Address							



Claim Number: 9452367

Employee Name (Last, First Middle Initial) Required  
DAVIS, ARTHUR

### Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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Employee's Signature

Date (MM/DD/YYYY)









PO Box 14560  
Lexington, KY 40512-4560  
800-354-1779

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**Facsimile Transmittal Sheet**

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To:		From:
Dr. Brenna Green		Aetna Disability
Employer:		Date:
Dell Inc		03/07/2014
Fax Number: 615-867-7974		CLAIM NUMBER:
		9452367
Phone number:		Sender's Phone Number:
		800-354-1779
		Sender's FAX Number:
		1-866-667-1987
Re: MR. ARTHUR DAVIS		Total No. of Pages Including Cover:
Date of Birth: REDACTED		

Urgent    For Review    Please Comment    xxPlease Reply    Please Recycle

Dear Dr. Green:

Please complete the attached form and submit to Aenta the intial evaluation. We are reviewing Mr. Davis for eligibility to receive LTD benefits. Thanks, Maribel

Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

---

The information contained in this document is CONFIDENTIAL. If you have received this in error, please fax immediately to 1-866-667-1987. Thank you.

Enclosed:  
Attending Physician Statement

Claim Number: 9452367



# **Attending Physician Statement – Musculoskeletal: Orthopaedic Surgery, Spinal Surgery, Physiatry, Podiatry, Chiro**

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

**1. Patient Information**

Name				Employer Name		Job Title	
Year of Birth	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No	Height (ft./in.)	Weight (lbs.)	BMI	Blood Pressure	Date Measured

**2. Physician Information**

Name		Specialty
Tax I.D. Number	Telephone Number (include area code)	Fax Number (include area code)

**3. Management Information**

Disability Benefits Manager <b>MARIBEL AMOR</b>	Telephone Number (include area code) <b>800-354-1779</b>	Fax Number (include area code) <b>1-866-667-1987</b>
--	---	---

**4. Treatment Information**

First Day recommended out of Work	Initial Treatment Date	Last Appointment Date	Surgery Date
Medication (Name, Dosage and Frequency)			
Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Hospitalization Admitted on ____ / ____ / ____ Discharged on ____ / ____ / ____	Recent Surgery Date (MM/DD/YYYY) ____ / ____ / ____	

**5. Clinical Condition**

Diagnosis	ICD9 Code(s)	Procedure (if applicable)	CPT Code(s)
Is this condition responsible for any functional impairment?		<input type="checkbox"/> Yes, complete <b>Sections 6, 7, 8 and 9</b> <input type="checkbox"/> No, provide a release to full duty in <b>Section 9</b>	
Is the condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Date of Injury / Illness ____ / ____ / ____	

**6. Treatment Plan**

Facility Name	Telephone Number (include area code)
Address (Include Zip Code)	

**7. Objective Data that documents a functional impairment**

Please record vital signs and describe physical exam (Quantitative ROM, Gait, Motor/Sensory/DTR, Neuro Findings, Effusions, Girth of Extremities) or WNL
Diagnostic Tests (X-Rays, CT / MRI, Myelogram, Discogram, Arthrogram, EMG/NCV, Bone Scans, Lab Test, etc.) or WNL
Other (PT/OT status, Pre & Post Surgical Indications and/or complications) or WNL

**8. Work Restrictions**

--

**9. Return to Work Status**

<input type="checkbox"/> Able to return to full duty on (date): ____ / ____ / ____
<input type="checkbox"/> Able to work with restrictions. Can return to work on (date): ____ / ____ / ____ Work restrictions will apply until (date): ____ / ____ / ____
<input type="checkbox"/> I am unable to release this patient. I anticipate significant clinical improvement by date: ____ / ____ / ____ Next appointment (date): ____ / ____ / ____

**10. Signature**

Physician's Signature	Date (MM/DD/YYYY) ____ / ____ / ____
Physician Name: _____	Specialty: _____
Phone Number: _____	Fax Number: _____
Address: _____	

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

WKAB- GR-68332 (7-13)



Claim Number: 9452367

Patient Name	Year of Birth
--------------	---------------

#### 11. Misrepresentation

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[[EMAILSUBJECT: DAVIS, A. - LTD Claim ID: 9452367]]Hi,

Please provide me with the job description for Mr. Davis. Thanks, Maribel

Client Name: Dell Inc  
EE Name: MR. ARTHUR DAVIS  
Work State: Tennessee  
Pref Cont #: REDACTED  
Claim Nbr: 9452367

Date of Hire: 05/22/2006

LTD Plan Name: DD

Claim Status: Pending

First Day Absent: 10/09/2013  
Last Day Worked: 10/08/2013  
Disability Date: 10/9/2013  
Benefit Begin Date: 4/7/2014  
Benefit End Date: 10/31/2028  
Approved Through:  
Total # Days Authorized:  
Max Benefit End Date: 10/31/2028 Status: Pend  
Reason: New Claim  
Return to work Information:  
Work Status: Not At Work  
Description:

Claim Owner: MARIBEL AMOR  
Phone: 800-354-1779, extension 6932140 Fax: 1-866-667-1987



PO Box 14560  
Lexington, KY 40512-4560  
800-354-1779

---

**Facsimile Transmittal Sheet**

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To:		From:
Dr. Cote		Aetna Disability
Employer:		Date:
Dell Inc		03/18/2014
Fax Number: 615-895-6212		CLAIM NUMBER:
		9452367
Phone number:		Sender's Phone Number:
		800-354-1779
		Sender's FAX Number:
		1-866-667-1987
Re: MR. ARTHUR DAVIS		Total No. of Pages Including Cover:
Date of Birth: REDACTED		

Urgent   For Review   Please Comment   xx Please Reply   Please Recycle

Dear Dr. Cote:

We are currently evaluating Mr. Davis for eligibility to receive LTD benefits. Please submit all the available records to Aetna. Mr. Davis has signed a release to have those records submitted to Aetna. Thanks, Maribel

Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

---

The information contained in this document is CONFIDENTIAL. If you have received this in error, please fax immediately to 1-866-667-1987. Thank you.

Enclosed:

[[EMAILSUBJECT: Response to your query]]RE: Medical Records from Dr. Cote/orthopedic surgeon

Dell Inc  
03/18/2014

Dear Mr. Davis:

This is to advise you that we have requested medical records from Dr. Cote on 02/26/2014, and 03/18/2014. You signed a release on 03/07/2014 to have the records submitted to Aetna. To date, we have not received the requested records.

Please note that it is also a plan requirement to apply for Social Security Disability. If you have not done so, you can apply online at [www.ssa.gov](http://www.ssa.gov) or let me know if Allsup our Social Security vendor can assist you with the process. Thanks Maribel

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>



PO Box 14560  
Lexington, KY 40512-4560

Phone: 800-354-1779  
Fax: 1-866-667-1987

March 18, 2014

ARTHUR DAVIS

REDACTED

MURFREESBORO TN - 37128

Dear Mr. Davis:

**We have more to offer**

If your medical insurance is with us, you have more benefits available to you. Just sign and return the attached form. It can help us:

- Make faster decisions on your claim
- Use less paper
- Get the information we need without waiting for your doctor to send it
- Offer you more programs that can help you

**What we need from you**

Sending the forms back to us is easy:

- You can fax the forms to us at **1-866-667-1987**
- Or, you can mail them to:

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560

- We've also included a self-addressed envelope!

**We're here to help you**

For questions about this packet or your claim, you can call us at **800-354-1779**. You can also visit us at **<https://www.aetnadisability.com>**.

Sincerely,

Aetna Life Insurance Company

Enclosure(s):

Return Envelope

Integrated Health and Disability Consent Form



## Authorization For Aetna to Disclose Protected Health Information (PHI) for Health and Disability Benefits Coordination

This authorization allows Aetna to disclose protected health information (PHI) to Aetna Disability Services which will be used to coordinate management of health care and disability benefits.

- Your ability to enroll in an Aetna plan, and your eligibility for benefits and payment for services, will not be affected if you do not sign this form.
- PHI provided under this authorization may include application or enrollment information, claim records, claim status and patient management information, diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information.
- Once PHI is provided to Aetna Disability Services, it is not protected by federal HIPAA privacy regulation but is protected by Aetna Privacy Policies.
- This authorization will expire twelve months after you sign this form, unless you direct us to terminate the authorization sooner. You may revoke this authorization at any time by notifying us in writing at the address below. The cancellation will apply from the date we receive your written notification.
- You may receive a copy of this form by requesting it in writing at the address below.
- You have a right to inspect or copy the PHI described above.
- Please return completed, signed authorization to the address below.

I hereby authorize Aetna and any of its parents, subsidiaries, or other affiliates (including, but not limited to, Aetna Health Management, Inc., Aetna's affiliated HMOs and Aetna Integrated Informatics, Inc.) and their respective employees, agents and subcontractors, to disclose Protected Health Information (PHI) of the member/insured listed below to Aetna Disability Services.

### 1. Member Information

Last name	First Name	MI
Member I D Number or Social Security Number		Birth Date (MM/DD/YYYY)
Street Address	City, State	Zip

### 2. Signature of Member/Insured or Legal Representative

SIGNATURE OF MEMBER/INSURED OR LEGAL REPRESENTATIVE	Date
Print Name	
<b>Please Check One</b> <input type="checkbox"/> Insured <input type="checkbox"/> Parent/Legal Guardian <input type="checkbox"/> Legal Representative*	
<small>*Legal Representatives must furnish a copy of the healthcare power of attorney or other relevant document designating you as the representative.</small>	

**Mail Form To:** Aetna Inc.  
PO Box 14560  
Lexington, KY 40512-4560

**Fax Number:** 1-866-667-1987

**Referring Aetna Office:** \_\_\_\_\_









PO Box 14560  
Lexington, KY 40512-4560  
800-354-1779

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**Facsimile Transmittal Sheet**

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To:		From:
Dr. Murfreesboro Results Physiotherapy		Aetna Disability
Employer:		Date:
Dell Inc		03/18/2014
Fax Number: 615-896-6825		CLAIM NUMBER:
		9452367
Phone number:		Sender's Phone Number:
		800-354-1779
		Sender's FAX Number:
		1-866-667-1987
Re: MR. ARTHUR DAVIS		Total No. of Pages Including Cover:
Date of Birth: REDACTED		

Urgent   For Review   Please Comment   xx Please Reply   Please Recycle

Please send me the progress notes and evaluations for March 2014. Mr. Davis is being evaluated to receive LTD benefits. Thanks, Maribel

Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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The information contained in this document is CONFIDENTIAL. If you have received this in error, please fax immediately to 1-866-667-1987. Thank you.

Enclosed:



PO Box 14560  
Lexington, KY 40512-4560  
800-354-1779

---

**Facsimile Transmittal Sheet**

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To:		From:
Kyle Todd, PT		Aetna Disability
Employer:		Date:
Dell Inc		03/20/2014
Fax Number:		CLAIM NUMBER:
681-401-3264		9452367
Phone number:		Sender's Phone Number:
		800-354-1779
		Sender's FAX Number:
		1-866-667-1987
Re: MR. ARTHUR DAVIS		Total No. of Pages Including Cover:
Date of Birth: REDACTED		

☐ Urgent   ☐ For Review   ☐ Please Comment   ☒ Please Reply   ☐ Please Recycle

Dear Mr. Todd:

Please submit the physical therapy notes and evaluations for the month of March 2014. Thanks, Maribel

Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

**Disclaimer:**

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**NOTICE TO RECIPIENT(S) OF INFORMATION:**

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The information contained in this document is CONFIDENTIAL. If you have received this in error, please fax immediately to 1-866-667-1987. Thank you.

Enclosed:

[[EMAILSUBJECT: DAVIS, A. - LTD Claim ID: 9452367]]Good afternoon!

Please send me the job description for Mr. Davis. We need to know if he is disabled from his own occupation with any employer. Thanks, Maribel

Client Name: Dell Inc  
EE Name: MR. ARTHUR DAVIS  
Work State: Tennessee  
Pref Cont #: **REDACTED**  
Claim Nbr: 9452367

Date of Hire: 05/22/2006

LTD Plan Name: DD

Claim Status: Pending

First Day Absent: 10/09/2013  
Last Day Worked: 10/08/2013  
Disability Date: 10/9/2013  
Benefit Begin Date: 4/7/2014  
Benefit End Date: 10/31/2028  
Approved Through: pending  
Total # Days Authorized:  
Max Benefit End Date: 10/31/2028 Status: Pend  
Reason: New Claim  
Return to work Information:  
Work Status: Not At Work  
Description:

Claim Owner: MARIBEL AMOR  
Phone: 800-354-1779, extension 6932140 Fax: 1-866-667-1987

[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
03/26/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

We have received all necessary paperwork for the claim. Your Claim Manager will send you a confirmation letter with the details about your claim, once the review has been completed.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>



PO Box 14560  
Lexington, KY 40512-4560  
800-354-1779

---

**Facsimile Transmittal Sheet**

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To:		From:
Dr. Brenna Green		Aetna Disability
Employer:		Date:
Dell Inc		04/03/2014
Fax Number: 615-867-7974		CLAIM NUMBER:
		9452367
Phone number:		Sender's Phone Number:
		800-354-1779
		Sender's FAX Number:
		1-866-667-1987
Re: MR. ARTHUR DAVIS		Total No. of Pages Including Cover:
Date of Birth: REDACTED		

Urgent    For Review    Please Comment    xx Please Reply    Please Recycle

Dear Ms. Green:

Please complete the attached form and provide us with all the progress notes and evaluations. Mr. Davis is being considered for Long Term Disability. Thanks, Maribel

Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

**Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

---

The information contained in this document is CONFIDENTIAL. If you have received this in error, please fax immediately to 1-866-667-1987. Thank you.

Enclosed:  
Attending Physician Statement

Claim Number: 9452367



**Attending Physician Statement –  
Musculoskeletal: Orthopaedic Surgery,  
Spinal Surgery, Physiatry, Podiatry, Chiro**

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

**1. Patient Information**

Name				Employer Name		Job Title	
Year of Birth	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No	Height (ft./in.)	Weight (lbs.)	BMI	Blood Pressure	Date Measured

**2. Physician Information**

Name		Specialty
Tax I.D. Number	Telephone Number (include area code)	Fax Number (include area code)

**3. Management Information**

Disability Benefits Manager <b>MARIBEL AMOR</b>	Telephone Number (include area code) <b>800-354-1779</b>	Fax Number (include area code) <b>1-866-667-1987</b>
--	---	---

**4. Treatment Information**

First Day recommended out of Work	Initial Treatment Date	Last Appointment Date	Surgery Date
Medication (Name, Dosage and Frequency)			
Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Hospitalization Admitted on ____ / ____ / ____ Discharged on ____ / ____ / ____	Recent Surgery Date (MM/DD/YYYY) ____ / ____ / ____	

**5. Clinical Condition**

Diagnosis	ICD9 Code(s)	Procedure (if applicable)	CPT Code(s)
Is this condition responsible for any functional impairment?		<input type="checkbox"/> Yes, complete <b>Sections 6, 7, 8 and 9</b> <input type="checkbox"/> No, provide a release to full duty in <b>Section 9</b>	
Is the condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Date of Injury / Illness ____ / ____ / ____	

**6. Treatment Plan**

Facility Name		Telephone Number (include area code)
Address (Include Zip Code)		

**7. Objective Data that documents a functional impairment**

Please record vital signs and describe physical exam (Quantitative ROM, Gait, Motor/Sensory/DTR, Neuro Findings, Effusions, Girth of Extremities) or WNL
Diagnostic Tests (X-Rays, CT / MRI, Myelogram, Discogram, Arthrogram, EMG/NCV, Bone Scans, Lab Test, etc.) or WNL
Other (PT/OT status, Pre & Post Surgical Indications and/or complications) or WNL

**8. Work Restrictions**

--

**9. Return to Work Status**

<input type="checkbox"/> Able to return to full duty on (date): ____ / ____ / ____
<input type="checkbox"/> Able to work with restrictions. Can return to work on (date): ____ / ____ / ____ Work restrictions will apply until (date): ____ / ____ / ____
<input type="checkbox"/> I am unable to release this patient. I anticipate significant clinical improvement by date: ____ / ____ / ____ Next appointment (date): ____ / ____ / ____

**10. Signature**

Physician's Signature	Date (MM/DD/YYYY) ____ / ____ / ____
Physician Name: _____	Specialty: _____
Phone Number: _____	Fax Number: _____
Address: _____	

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

WKAB- GR-68332 (7-13)



Claim Number: 9452367

Patient Name	Year of Birth
--------------	---------------

#### 11. Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

WKAB  
GR-68332 (7-13)

Page 2





[[EMAILSUBJECT: Response to your query]]**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
04/28/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager along with a request to call you. She will call you in the next 24 business hours. Be advised, when someone from Aetna calls you, it may show on your caller ID as blocked, restricted or unknown, so please answer those calls.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: [www.aetnadisability.com](http://www.aetnadisability.com)

[[EMAILSUBJECT: Response to your query]]**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
05/05/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

We forwarded your email to your Claim Manager along with a request to call you. She will call you in the next 24 business hours. Be advised, when someone from Aetna calls you, it may show on your caller ID as blocked, restricted or unknown, so please answer those calls.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: [www.aetnadisability.com](http://www.aetnadisability.com)



PO Box 14560  
Lexington, KY 40512-4560  
WANDA GREENE CELESTINE  
SENIOR TECHNICAL SPECIALIST  
Phone: 800-354-1779  
Fax: 1-866-667-1987

05/07/2014

Dr. JAMES RENFRO  
394 HARDING PLACE S 200  
NASHVILLE TN - 37211

Group Control No: 0476626  
Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

Dear Dr. Renfro:

The Dell Inc. group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna). To properly evaluate their eligibility for continued disability benefits, information is needed from your office.

Please include current office and/or chart notes, along with any medical documentation you may have including, labs, blood work, physical exam, MRI/x-ray, and the results of any other diagnostic test from the last 2 office visit.

Dell Inc.'s Program requires a clinical review of the medical appropriateness for your patient's work absence. Your office can fax the documents to 1-866-667-1987 or mail them to:

Aetna Life Insurance Company  
Dell Inc. LTD Program  
PO Box 14560  
Lexington, KY 40512-4560

It is important to understand that if we do not receive the requested documentation by May 22, 2014 your patient's case may be closed and benefits may be terminated.

Should you have any questions regarding your claim, please call 800-354-1779 and an Aetna Customer Service Representative will be happy to assist you.

Sincerely,

Wanda Greene Celestine  
Senior Technical Specialist  
Aetna Life Insurance Company



PO Box 14560  
Lexington, KY 40512-4560  
SHAWNDR A LEE  
STD BENEFIT MANAGER  
Phone: 800-354-1779  
Fax: 1-866-667-1987

05/07/2014

ARTHUR DAVIS

REDACTED

MURFREESBORO TN - 37128

Group Control No: 0476626  
Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

Dear Mr. Davis:

To be eligible for monthly disability benefits you must be unable to perform the material duties of your own occupation solely due to injury or illness. We have reviewed your claim for long term disability benefits and have determined that, according to your plan, you are now totally disabled from your own occupation. You are eligible to receive monthly benefits effective April 7, 2014 and continuing for up to 24 months as long as you remain disabled from your own occupation.

#### Criteria for Continuation of Benefits

We have determined that you presently meet the "own occupation" definition of disability. Your plan provides benefits in the event you become totally disabled as defined below, and are unable to work because of that disability. According to your Long Term Disability Plan the definition of disability states:

From the date that you first become disabled and until Monthly Benefits are payable for 18 months, you will be deemed to be disabled on any day if:

- you are not able to perform the material duties of your own occupation solely because of: disease or injury; and
- your work earnings are 80% or less of your adjusted predisability earnings.

Your plan requires that we periodically re-evaluate your eligibility by requesting updated medical information from your physician or an independent physician of our choice. Also, you may be contacted by a Vocational Rehabilitation Consultant and asked to participate in a vocational assessment interview. If we determine that you are capable of performing the material duties of your own occupation, your monthly benefits will cease. If you are still disabled from your own occupation and eligible for disability benefits on April 7, 2016 your plan requires that you meet a more strict definition of disability.

Your plan provides benefits after the first 24 months that any Monthly Benefit is payable during a period of disability only if you are deemed to be disabled on any day if you are not able to work at any reasonable occupation solely because of:

- disease; or
- injury.

If your own occupation requires a professional or occupational license or certification of any kind, you will not be deemed to be disabled solely because of the loss of that license or certification.

To qualify for monthly benefits, you must provide medical evidence that you are unable to perform any reasonable occupation for which you are qualified or could become qualified as a result of your education, training or experience. If you do qualify for continuation of benefits, we will periodically review your eligibility by requesting updated medical information from your medical providers, independent physicians of our choice, or vocational specialists.

While you are eligible and are receiving benefits, you may be contacted by an Aetna representative regarding our rehabilitation program or our Social Security Advocate. The assistance program is voluntary and is of no cost to you. As these services may be highly beneficial, we encourage you to participate when requested.

In accordance with contractual provisions, your maximum period of benefit entitlement will end October 31, 2028.

If your disability is due to any extent to a mental condition, your plan provision limits your benefits as follows:

A period of disability will end after 24 monthly benefits are payable if it is determined that the disability is primarily caused by: a Mental Health or Psychiatric condition, including physical manifestations of these conditions, but excluding those conditions with demonstrable, structural brain damage; or Alcohol and/or Drug Abuse.

There are two exceptions which apply if you are confined as an inpatient in a hospital or treatment facility for treatment of that condition at the end of such 24 months.

- If the inpatient confinement lasts less than 30 days, the period of disability will cease when you are no longer confined.
- If the inpatient confinement lasts 30 days or more, the period of disability may continue until 90 days after the date you have not been so continuously confined.

The Separate Periods of Disability section does not apply beyond 24 months to periods of disability which are subject to the above paragraph.

LTD benefits supplement certain other income described in the enclosed Notice Concerning Benefits. The total amount from all applicable sources will not be less than 60% of your Monthly Rate of Basic Earnings (MRBE) of \$5,284.34 at the time your disability began. Your gross monthly LTD benefit will be \$3,170.61 less any other sources of income you may be eligible to receive such as Workers Compensation, Social Security Benefits or State Disability benefits.

Please carefully read the instructions on the enclosed Notice Concerning Benefits. Failure to comply with each applicable provision may jeopardize your future eligibility.

Social Security (FICA) withholding is required during the first six full months of disability. FICA withholding will cease if you continue to remain totally disabled beyond six full calendar months.

Under the terms of your plan there is a minimum monthly benefit of \$100 or 10% of the gross monthly benefit which ever is greater.

Direct deposit service is a convenient way to automatically deposit your benefit payment into your checking or savings account at your local banking institution. Enclosed is an application if you would like to use the Electronic Funds Transfer (EFT) system.

You will receive your initial payment of \$2,536.49 representing benefits due for the period April 7, 2014 through April 30, 2014. All benefits are due at the end of each month.

Should you have any questions regarding your claim, please call 800-354-1779 and an Aetna Customer Service Representative will be happy to assist you.

Sincerely,

SHAWNDR A LEE  
STD BENEFIT MANAGER  
Aetna Life Insurance Company

Enclosures:  
Notice Concerning Benefits  
Authorization for Direct Deposit of Disability Benefit Payment

# **aetna<sup>®</sup>** Notice Concerning Benefits

## **PLEASE READ CAREFULLY AND RETAIN**

The benefits provided under this plan are a supplement to certain basic income to which you are or may become entitled, such as Federal Social Security. The plan may require you to apply for, not only Social Security, but also certain other disability benefits which may be due you. Aetna Life Insurance Company may advance to you the unreduced disability benefit prior to your receiving other types of basic income if you will follow the steps outlined below:

1. You may be asked, at some future date, to apply for Social Security benefits. If an application is required, Aetna Life Insurance Company has contracted Allsup, Inc. to contact you and assist you with your application for these benefits.
2. If you have already applied for Social Security benefits and your Social Security claim has been approved, please send us a copy (or the original, which will be copied and returned to you) of the award notice immediately. If you receive a payment from Social Security before an award notice, notify us of the amount immediately. If your Social Security is denied, we will need a copy of that notice. Reapplication should be made within 60 days of the date of the denial notice.

**Note: Social Security benefits payable to your eligible dependents as a result of your disability may also reduce your disability entitlement.**

3. Your first Social Security payment may be retroactive to the sixth month of disability. This may create an overpayment of your disability benefits and you then will be asked to reimburse the disability plan. Therefore, when you receive the retroactive check, and/or award letter, you should send us a copy of the award letter and put the retroactive check in the bank. We then will calculate the overpayment and send you a letter advising you of the amount of the overpayment and how it was calculated. We are required under the plan provisions to seek full reimbursement for all overpayments.
4. Notify us promptly of any income you receive from any of the following sources: Self-employment, any employer, a labor-management plan, union welfare or employee benefit plan, any compulsory benefit act or law, retirement, Railroad Retirement Act, Veterans Administration, any federal, state, municipal, or other government agency, pursuant to any Worker's Compensation law, occupational disease law, maritime doctrine of maintenance, wages, and cure, or any payment for disability under a group insurance plan. Failure to promptly notify us of income from any of the above sources may cause an overpayment, which will be subject to collection at a time that may be less convenient for you.
5. The benefits payable under the disability plan may be subject to Federal Income Tax. Aetna is required to report such benefits annually to Internal Revenue Service. Any information regarding taxability of these benefits should be obtained from the IRS.







Claim Number: 9452367



## Authorization for EFT/Direct Deposit of Disability Benefit Payment

It's easy to set up EFT payments for disability benefits. All you have to do is complete the form below or you may visit us at **www.aetnadisability.com**. If you would prefer to complete via the form **please sign and return** the form to Aetna at the address below or you may also fax your information to **1-866-667-1987**.

**Aetna Life Insurance Company (Aetna)**  
**PO Box 14560**  
**Lexington, KY 40512-4560**  
**Phone: 800-354-1779**  
**Fax: 1-866-667-1987**

☐ New ☐ Change ☐ Cancel

**Employee Information - ALL fields must be completed.**

Name		Telephone (     )	
Street Address			
City		State	ZIP Code
Social Security Number     -     -			

**Banking Information - ALL fields must be completed.**

Name of Financial Institution		Telephone (     )	
Please indicate: <input type="checkbox"/> Checking <b>OR</b> <input type="checkbox"/> Savings <b>and</b> <b>ATTACH</b> a copy of a blank check, marked "VOID <b>OR</b> provide the information below: Routing Number: _____ Account Number: _____			
<b>ATTACH HERE</b>	<b>** Please attach a blank check from your Checking Account, marked "VOID" **</b>		
	If Electronic Funds Transfer (EFT) is available at your financial institution Aetna will send a pre-notification transaction to your financial institution for confirmation. Please allow time for EFT information to be processed by Aetna, which is approximately 10 calendar days from Aetna's receipt of this completed information. Upon completion of the pre-notification process, Aetna will transmit benefit payments via EFT. You may continue to receive benefit payments via check until this process is complete.		

### Authorization Agreement

I authorize Aetna to initiate electronic funds transfers to my account at the financial institution associated with the routing number I entered for all benefit payments on my behalf. This agreement will remain in effect until I provide written notice to withdraw from the direct deposit service or until Aetna or my employer notifies me that this service has been terminated. I understand that I must allow approximately 10 calendar days from Aetna's receipt of this information for my instructions to be executed. If Aetna credits more money to said account than the correct benefit amount to which I am entitled due to duplicate or erroneous funds transfers, I authorize the financial institution to allow Aetna to reverse the transactions. If the reversal is denied by my financial institution, I agree to repay said amounts to Aetna.	
<b>Authorized Signature(s)</b>	<b>Date</b>

EFT GR-68735 (2-12) C

R-POD



[[EMAILSUBJECT: DAVIS, A. - LTD Claim ID: 9452367]]

Client Name: Dell Inc  
EE Name: MR. ARTHUR DAVIS  
Work State: Tennessee  
Pref Cont #: **REDACTED**  
Claim Nbr: 9452367

Date of Hire: 05/22/2006

LTD Plan Name: DD

Claim Status: Approved

First Day Absent: 10/09/2013  
Last Day Worked: 10/08/2013  
Disability Date: 10/9/2013  
Benefit Begin Date: 4/7/2014  
Benefit End Date: 10/31/2028  
Approved Through: 04/06/2016  
Total # Days Authorized:  
Max Benefit End Date: 10/31/2028  
Status: Approved  
Reason: Disability Supported  
Return to work Information:  
Work Status: Not At Work  
Description:

Claim Owner: SHAWNDR LEE  
Phone: 800-354-1779, extension 6932227 Fax: 1-866-667-1987



PO Box 14560  
Lexington, KY 40512-4560  
SHAWNDR A LEE  
LTD BENEFIT MANAGER  
Phone: 800-354-1779  
Fax: 1-866-667-1987

08/15/2014

Dr. Tad Yoneyama Heritage Medical  
2339 Hillsboro Road  
Franklin TN - 37069

Group Control No: 0476626  
Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

Dear Dr. Yoneyama:

The Dell Inc. group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna). To properly evaluate their eligibility for continued disability benefits, information is needed from your office.

Please include current office and/or chart notes, along with any medical documentation you may have including, labs, blood work, physical exam, MRI/x-ray, and the results of any other diagnostic test from July 2014 office visit. We also ask that you complete the attached Attending Physician Statement and Capabilities and Limitations Work Sheet.

Dell Inc.'s Program requires a clinical review of the medical appropriateness for your patient's work absence. Your office can fax the documents to 1-866-667-1987 or mail them to:

Aetna Life Insurance Company  
Dell Inc. LTD Program  
PO Box 14560  
Lexington, KY 40512-4560

It is important to understand that if we do not receive the requested documentation by August 30, 2014 your patient's case may be closed and benefits may be terminated.

Should you have any questions regarding your claim, please call 800-354-1779 and an Aetna Customer Service Representative will be happy to assist you.

Should you have any questions regarding your claim, please call 800-354-1779 and an Aetna Customer Service Representative will be happy to assist you.

Sincerely,

SHAWNDR A LEE  
LTD BENEFIT MANAGER  
Aetna Life Insurance Company

Enclosures:

Attending Physician Statement  
Capabilities and Limitations Worksheet

Claim Number: 9452367



## Attending Physician Statement

Complete and sign the form using **BLUE** or **BLACK** ink.

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

- 1. Patient Instructions** – The Physician will complete Sections 2 through 7.  
The Patient will complete Sections 1 and 8.  
The Patient should also fill in their name at the top of Pages 2 and 3.

The **Patient** is responsible for completing this section and for **ensuring** that their **Attending Physician completes the remainder of this statement**. The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. **If you have any questions, please call 800-354-1779.**

(a) Control Number 0476626

(b) DAVIS, ARTHUR / REDACTED / REDACTED / REDACTED / REDACTED  
Patient Name (Last, First, Middle Initial) Social Security Number Year of Birth Height Weight (lbs)

(c) Patient Gender ☐ Male ☐ Female

(d) Patient Home Address – Required (Current No., Street, Town, State, ZIP – no PO boxes) ☐ Check if New

(e) Mailing Address, if different from Home Address \_\_\_\_\_

(f) Patient Employer Name/City/State Dell Inc

(g) Patient Telephone Number \_\_\_\_\_ ☐ Check if New

(h) Job Title/Occupation Inside Sales Account Mgmt lii

(i) Type of Claim: ☐ Short Term Disability ☐ Long Term Disability ☐ Waiver of Premium  
☐ Long Term / Permanent Total Disability

### 2. Physician Instructions

The **Attending Physician** should **complete the items below**, based upon a **recent examination**. Attach additional documentation as needed. If you have any questions, please call **800-354-1779**.  
**Please complete form in its entirety and fax to 1-866-667-1987. Pages 2 and 3 MUST be completed before faxing.**

### 3. Impairing Diagnosis & Treatment

(a) **For medical reasons, the patient will need to be absent from work due to a disability beginning on** MM/DD/YYYY **and ending on** MM/DD/YYYY.

(b) Primary Diagnosis \_\_\_\_\_ Primary ICD Code \_\_\_\_\_  
Secondary Diagnosis \_\_\_\_\_ Secondary ICD Code \_\_\_\_\_  
Other Diagnoses \_\_\_\_\_ Other ICD Codes \_\_\_\_\_

(c) Height \_\_\_\_\_ Weight \_\_\_\_\_ Date Measured (MM/DD/YYYY) \_\_\_\_\_

(d) If Pregnancy related, delivery or expected due date Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Delivery Type: ☐ Vaginal ☐ Cesarean

(e) Surgery Date \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Primary Procedure \_\_\_\_\_ Primary CPT Code \_\_\_\_\_  
Secondary Procedure \_\_\_\_\_ Secondary CPT Code \_\_\_\_\_  
Other Procedures \_\_\_\_\_ Other CPT Codes \_\_\_\_\_

(f) Medication(s)/Dose/Frequency \_\_\_\_\_  
Impairment from medication effects \_\_\_\_\_

(g) Is patient still under your care for this condition? ☐ Yes ☐ No Date service terminated \_\_\_\_\_ (MM/DD/YYYY)

(h) Treatment Summary \_\_\_\_\_

(i) Office Visit Dates: First \_\_\_\_\_ Last \_\_\_\_\_ Next \_\_\_\_\_ Frequency of appointments \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY) (MM/DD/YYYY)

(j) Was patient recently hospitalized? ☐ No ☐ Yes Date hospitalized: Admit \_\_\_\_\_ Discharge \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

(k) Hospital Name/City/State \_\_\_\_\_

WKAB- GC-1486-26 (7-13) C R-POD



Patient Name (Last, First, Middle Initial) **Required**

DAVIS, ARTHUR

**4. History**

(a) Symptoms: \_\_\_\_\_

(b) Date symptoms first appeared or accident happened Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

(c) Has patient ever had same or similar condition? ☐ No ☐ Yes State when and describe. \_\_\_\_\_

(e) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown

(f) Other Treating Physicians

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**5. Abilities/Limitations**

(a) **Patient is: Place remarks in item (d) below, if applicable.**

- Competent to endorse checks and direct the use of proceeds thereof .... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to work with others ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to give supervision ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to work cooperatively with others in group setting ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to do? **Select one: Place remarks in item (d) below, if applicable.**
  - ☐ **Heavy work** activity. No limitations of functional capacity.
  - ☐ **Medium work** activity. Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly.
  - ☐ **Light work** activity. Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently.
  - ☐ **Sedentary work** activity. Moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. (Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.)
  - ☐ **No ability to work.** Severe limitation of functional capacity; incapable of minimal activity.
  - ☐ **Other.** Place remarks in item (d) below.

(b) **What medical restrictions/limitations are you placing on patient? (Activities of Daily Living, Driving, Lifting, Pulling, Pushing, and Amounts, etc.)** \_\_\_\_\_

\_\_\_\_\_

• Number of Hours patient is capable of working in a day: ☐ 12 ☐ 10 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐ 1 Hour/Day

• Number of Days per week patient is able to work: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week

• Date you prescribed restriction on work activities: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

• How long are these restrictions/limitations in effect? \_\_\_\_\_ ☐ No Longer

Days Weeks Months

• Estimated return to work date? \_\_\_\_\_ Modified Duty \_\_\_\_\_ Full Duty

(MM/DD/YYYY) (MM/DD/YYYY)

(c) **Objective findings that substantiate impairment** (current laboratory, physical and/or mental status examination and other testing) \_\_\_\_\_

(d) Other/Comments \_\_\_\_\_

**6. Current Status**

(a) Patient has ☐ Improved ☐ Stabilized ☐ Regressed ☐ Not Applicable

(b) Is there a medical contraindication for patient to participate in Vocational Rehabilitation (job training) programs?  
☐ No ☐ Yes, please explain \_\_\_\_\_

(c) In your opinion, is your patient motivated to return to work? \_\_\_\_\_

**7. Physician Information**

Attending Physician's Name ( <i>Print</i> )	Degree	Specialty
Address (No. Street, City, State, ZIP Code)	Telephone Number	Fax Number
Signature		Date (MM/DD/YYYY)

WKAB

GC-1486-26 (7-13) C



Claim Number: 9452367

Patient Name (Last, First, Middle Initial) **Required**  
DAVIS, ARTHUR

#### 8. Regulation Notice

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

WKAB  
GC-1486-26 (7-13) C

Pa



Claim Number: 9452367



# Capabilities and Limitations Worksheet

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

Employee Name ( <i>Last, First, Middle Initial</i> ) <b>DAVIS, ARTHUR</b>		Social Security Number	Year of Birth
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Job Title		Control Number <b>0476626</b>
Current Diagnosis _____ _____		Medications: _____ _____	

Indicate the percent of the day the following activities can be performed:  
(**O**ccasional 1-33% or .5-2.5 hrs. **F**requent 34-66% or 2.6-5.0 hrs. **C**ontinuous 67-100% or 5.1-8 hrs. or **N**ever)

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<p>Maximum weight patient is capable of lifting:</p> <table style="width:100%;"> <tr> <th></th> <th><b>O</b></th> <th><b>F</b></th> <th><b>C</b></th> <th><b>N</b></th> </tr> <tr><td>1 - 5 lbs.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>6 - 10 lbs.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>11 - 20 lbs.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>21 - 35 lbs.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>36 - 50 lbs.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>51 - 75 lbs.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>75 - 100 lbs.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>100 lbs. +</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table>		<b>O</b>	<b>F</b>	<b>C</b>	<b>N</b>	1 - 5 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 - 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 - 20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21 - 35 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	36 - 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51 - 75 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	75 - 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	100 lbs. +	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Approved Head and Neck Movements:</p> <table style="width:100%;"> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> <tr><td>Static Position</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Frequent Flexing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Frequent Rotation</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Can the Patient operate:</p> <table style="width:100%;"> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> <tr><td>A Motor Vehicle</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Hazardous Machine</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Power Tools</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table>		Yes	No	Static Position	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Flexing	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Rotation	<input type="checkbox"/>	<input type="checkbox"/>		Yes	No	A Motor Vehicle	<input type="checkbox"/>	<input type="checkbox"/>	Hazardous Machine	<input type="checkbox"/>	<input type="checkbox"/>	Power Tools	<input type="checkbox"/>	<input type="checkbox"/>
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<p>Limitations to:</p> <p>Speaking _____ hrs.</p> <p>Vision (explain) _____</p> <p>Depth Perception _____</p> <p>Hearing (explain) _____</p>	<p>Exposure Limitations: Yes No</p> <table style="width:100%;"> <tr><td>Heat</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Cold</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Dampness</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Noise</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>Yes No</p> <table style="width:100%;"> <tr><td>Dust</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Fumes</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Chemicals</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Radiation</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table>	Heat	<input type="checkbox"/>	<input type="checkbox"/>	Cold	<input type="checkbox"/>	<input type="checkbox"/>	Dampness	<input type="checkbox"/>	<input type="checkbox"/>	Noise	<input type="checkbox"/>	<input type="checkbox"/>	Dust	<input type="checkbox"/>	<input type="checkbox"/>	Fumes	<input type="checkbox"/>	<input type="checkbox"/>	Chemicals	<input type="checkbox"/>	<input type="checkbox"/>	Radiation	<input type="checkbox"/>	<input type="checkbox"/>
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Chemicals	<input type="checkbox"/>	<input type="checkbox"/>																							
Radiation	<input type="checkbox"/>	<input type="checkbox"/>																							

Total # of hours patient capable of working per day: 12 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐

Duration of restrictions: \_\_\_\_\_ Care Complete: Yes ☐ No ☐ Next Appointment: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WKAB  
GC-1500-26 (7-13)

Page 1 of 2





Claim Number: 9452367

Employee Name (Last, First Middle Initial) Required  
DAVIS, ARTHUR

### Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Employee's Signature

Date (MM/DD/YYYY)







[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
05/23/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

We are able to provide you an income verification letter. We have forwarded a request to your Claim Manager to send the letter to you.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: [www.aetnadisability.com](http://www.aetnadisability.com)

[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
05/28/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: [www.aetnadisability.com](http://www.aetnadisability.com)

[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
05/30/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your request has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: [www.aetnadisability.com](http://www.aetnadisability.com)



PO Box 14560  
Lexington, KY 40512-4560  
WANDA GREENE-CELESTINE  
Senior Technical Specialist  
Phone: 800-354-1779  
Fax: 1-866-667-1987

06/02/2014

ARTHUR DAVIS

**REDACTED**

MURFREESBORO TN - 37128

Group Control No: 0476626  
Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

To Whom It May Concern:

We are in receipt of your request for verification of Long Term Disability benefits of Arthur Davis. Aetna Inc. is the claim administrator for the LTD Policy under which Mr. Davis is currently receiving Long Term Disability benefits.

Mr. Davis has been a recipient of LTD benefits, which are distributed on a monthly basis, beginning April 7, 2014 through present. His monthly benefit is \$3,170.61. Mr. Davis' monthly LTD benefits will continue as long as he meets the eligibility requirements under the Policy.

Should you have any questions, please do not hesitate to contact me at the number below.

If you have any questions, please call 800-354-1779.

Sincerely,  
WANDA GREENE-CELESTINE  
Senior Technical Specialist  
Aetna Life Insurance Company



PO Box 14560  
Lexington, KY 40512-4560  
WANDA GREENE-CELESTINE  
Senior Technical Specialist  
Phone: 800-354-1779  
Fax: 1-866-667-1987

06/02/2014

ARTHUR DAVIS

**REDACTED**

MURFREESBORO TN - 37128

Group Control No: 0476626  
Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

Dear Mr. Davis:

The Dell Inc group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna).

We are writing to you regarding your Long-Term Disability (LTD) benefits provided by your employer, Dell Inc, under the above referenced plan.

As we discussed, enclosed is a treating provider form. Please list all treating providers and return to Aetna.

If you have any questions, please call 800-354-1779.

Sincerely,

WANDA GREENE-CELESTINE  
Senior Technical Specialist  
Aetna Life Insurance Company

treating-provider.pdf



# aetna<sup>®</sup> Medical Professionals List

**Return completed form to:**  
Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
**Fax:** 1-866-667-1987

In the space provided below, please list the complete names, specialty, addresses, phone and fax numbers of all medical professionals you have consulted for the past two years. If necessary, you may use the back of this form to list additional medical providers, pharmacies, hospitals, or any other pertinent information regarding your disability.

<b>Employee Name</b> DAVIS, ARTHUR	<b>Claim #</b> Claim Number: 9452367
---------------------------------------	---

Medical Provider / Hospital / Pharmacy: \_\_\_\_\_

Specialty: \_\_\_\_\_ Period Consulted: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Medical Provider / Hospital / Pharmacy: \_\_\_\_\_

Specialty: \_\_\_\_\_ Period Consulted: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Medical Provider / Hospital / Pharmacy: \_\_\_\_\_

Specialty: \_\_\_\_\_ Period Consulted: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Medical Provider / Hospital / Pharmacy: \_\_\_\_\_

Specialty: \_\_\_\_\_ Period Consulted: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Medical Provider / Hospital / Pharmacy: \_\_\_\_\_

Specialty: \_\_\_\_\_ Period Consulted: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_



<b>Employee Name</b> DAVIS, ARTHUR	<b>Claim #</b> Claim Number: 9452367
---------------------------------------	---

Medical Provider / Hospital / Pharmacy: \_\_\_\_\_

Specialty: \_\_\_\_\_ Period Consulted: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Medical Provider / Hospital / Pharmacy: \_\_\_\_\_

Specialty: \_\_\_\_\_ Period Consulted: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Medical Provider / Hospital / Pharmacy: \_\_\_\_\_

Specialty: \_\_\_\_\_ Period Consulted: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Medical Provider / Hospital / Pharmacy: \_\_\_\_\_

Specialty: \_\_\_\_\_ Period Consulted: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Medical Provider / Hospital / Pharmacy: \_\_\_\_\_

Specialty: \_\_\_\_\_ Period Consulted: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Medical Provider / Hospital / Pharmacy: \_\_\_\_\_

Specialty: \_\_\_\_\_ Period Consulted: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_







PO Box 14560  
Lexington, KY 40512-4560  
SHAWNDR LEE  
STD BENEFIT MANAGER  
Phone: 800-354-1779  
Fax: 1-866-667-1987

06/16/2014

Tad Yoneyama Heritage Medical  
2339 Hillsboro Road  
Franklin TN - 37069

Group Control No: 0476626  
Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

To Whom It May Concern:

The Dell Inc. group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna). To properly evaluate their eligibility for continued disability benefits, information is needed from your office.

Please include current office and/or chart notes, along with any medical documentation you may have including, labs, blood work, physical exam, MRI/x-ray, and the results of any other diagnostic test from the last office visit. We also ask that you complete the attached Attending Physician Statement and Capabilities and Limitations Work Sheet.

Dell Inc.'s Program requires a clinical review of the medical appropriateness for your patient's work absence. Your office can fax the documents to 1-866-667-1987 or mail them to:

Aetna Life Insurance Company  
Dell Inc. LTD Program  
PO Box 14560  
Lexington, KY 40512-4560

It is important to understand that if we do not receive the requested documentation by July 1, 2014 your patient's case may be closed and benefits may be terminated.

Should you have any questions regarding your claim, please call 800-354-1779 and an Aetna Customer Service Representative will be happy to assist you.

Sincerely,

Wanda Greene Celestine  
Senior Technical Specialist  
Aetna Life Insurance Company

Enclosures:  
Attending Physician Statement  
Capabilities and Limitations Worksheet

Claim Number: 9452367



## Attending Physician Statement

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: 800-354-1779  
Fax: 1-866-667-1987

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

- 1. Patient Instructions** – The Physician will complete Sections 2 through 7.  
The Patient will complete Sections 1 and 8.  
The Patient should also fill in their name at the top of Pages 2 and 3.

The **Patient** is responsible for completing this section and for **ensuring** that their **Attending Physician completes the remainder of this statement**. The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. **If you have any questions, please call 800-354-1779.**

(a) Control Number 0476626

(b) DAVIS, ARTHUR / REDACTED / REDACTED / REDACTED / REDACTED  
Patient Name (Last, First, Middle Initial) Social Security Number Year of Birth Height Weight (lbs)

(c) Patient Gender ☐ Male ☐ Female

(d) Patient Home Address – Required (Current No., Street, Town, State, ZIP – no PO boxes) ☐ Check if New

(e) Mailing Address, if different from Home Address \_\_\_\_\_

(f) Patient Employer Name/City/State Dell Inc

(g) Patient Telephone Number \_\_\_\_\_ ☐ Check if New

(h) Job Title/Occupation Inside Sales Account Mgmt lii

(i) Type of Claim: ☐ Short Term Disability ☐ Long Term Disability ☐ Waiver of Premium  
☐ Long Term / Permanent Total Disability

### 2. Physician Instructions

The **Attending Physician** should **complete the items below**, based upon a **recent examination**. Attach additional documentation as needed. If you have any questions, please call **800-354-1779**.  
**Please complete form in its entirety and fax to 1-866-667-1987. Pages 2 and 3 MUST be completed before faxing.**

### 3. Impairing Diagnosis & Treatment

(a) **For medical reasons, the patient will need to be absent from work due to a disability beginning on** MM/DD/YYYY **and ending on** MM/DD/YYYY.

(b) Primary Diagnosis \_\_\_\_\_ Primary ICD Code \_\_\_\_\_  
Secondary Diagnosis \_\_\_\_\_ Secondary ICD Code \_\_\_\_\_  
Other Diagnoses \_\_\_\_\_ Other ICD Codes \_\_\_\_\_

(c) Height \_\_\_\_\_ Weight \_\_\_\_\_ Date Measured (MM/DD/YYYY) \_\_\_\_\_

(d) If Pregnancy related, delivery or expected due date Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Delivery Type: ☐ Vaginal ☐ Cesarean

(e) Surgery Date \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Primary Procedure \_\_\_\_\_ Primary CPT Code \_\_\_\_\_  
Secondary Procedure \_\_\_\_\_ Secondary CPT Code \_\_\_\_\_  
Other Procedures \_\_\_\_\_ Other CPT Codes \_\_\_\_\_

(f) Medication(s)/Dose/Frequency \_\_\_\_\_  
Impairment from medication effects \_\_\_\_\_

(g) Is patient still under your care for this condition? ☐ Yes ☐ No Date service terminated \_\_\_\_\_  
(MM/DD/YYYY)

(h) Treatment Summary \_\_\_\_\_

(i) Office Visit Dates: First \_\_\_\_\_ Last \_\_\_\_\_ Next \_\_\_\_\_ Frequency of appointments \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY) (MM/DD/YYYY)

(j) Was patient recently hospitalized? ☐ No ☐ Yes Date hospitalized: Admit \_\_\_\_\_ Discharge \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

(k) Hospital Name/City/State \_\_\_\_\_

WKAB- GC-1486-26 (7-13) C R-POD



Patient Name (Last, First, Middle Initial) **Required**

DAVIS, ARTHUR

**4. History**

(a) Symptoms: \_\_\_\_\_

(b) Date symptoms first appeared or accident happened Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

(c) Has patient ever had same or similar condition? ☐ No ☐ Yes State when and describe. \_\_\_\_\_

(e) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown

(f) Other Treating Physicians

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**5. Abilities/Limitations**

(a) **Patient is: Place remarks in item (d) below, if applicable.**

- Competent to endorse checks and direct the use of proceeds thereof .... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to work with others ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to give supervision ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to work cooperatively with others in group setting ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to do? **Select one: Place remarks in item (d) below, if applicable.**
  - ☐ **Heavy work** activity. No limitations of functional capacity.
  - ☐ **Medium work** activity. Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly.
  - ☐ **Light work** activity. Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently.
  - ☐ **Sedentary work** activity. Moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. (Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.)
  - ☐ **No ability to work.** Severe limitation of functional capacity; incapable of minimal activity.
  - ☐ **Other.** Place remarks in item (d) below.

(b) **What medical restrictions/limitations are you placing on patient? (Activities of Daily Living, Driving, Lifting, Pulling, Pushing, and Amounts, etc.)** \_\_\_\_\_

\_\_\_\_\_

• Number of Hours patient is capable of working in a day: ☐ 12 ☐ 10 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐ 1 Hour/Day

• Number of Days per week patient is able to work: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week

• Date you prescribed restriction on work activities: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

• How long are these restrictions/limitations in effect? \_\_\_\_\_ ☐ No Longer

Days Weeks Months

• Estimated return to work date? \_\_\_\_\_ Modified Duty \_\_\_\_\_ Full Duty

(MM/DD/YYYY) (MM/DD/YYYY)

(c) **Objective findings that substantiate impairment** (current laboratory, physical and/or mental status examination and other testing) \_\_\_\_\_

\_\_\_\_\_

(d) Other/Comments \_\_\_\_\_

\_\_\_\_\_

**6. Current Status**

(a) Patient has ☐ Improved ☐ Stabilized ☐ Regressed ☐ Not Applicable

(b) Is there a medical contraindication for patient to participate in Vocational Rehabilitation (job training) programs?  
☐ No ☐ Yes, please explain \_\_\_\_\_

(c) In your opinion, is your patient motivated to return to work? \_\_\_\_\_

**7. Physician Information**

Attending Physician's Name ( <i>Print</i> )	Degree	Specialty
Address (No. Street, City, State, ZIP Code)	Telephone Number	Fax Number
Signature		Date (MM/DD/YYYY)

WKAB

GC-1486-26 (7-13) C



Claim Number: 9452367

Patient Name (Last, First, Middle Initial) **Required**  
DAVIS, ARTHUR

#### 8. Regulation Notice

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

WKAB  
GC-1486-26 (7-13) C

Pa



Claim Number: 9452367



# Capabilities and Limitations Worksheet

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

Employee Name (Last, First, Middle Initial) <b>DAVIS, ARTHUR</b>		Social Security Number	Year of Birth								
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Job Title		Control Number <b>0476626</b>								
Current Diagnosis		Medications:									
<p>Indicate the percent of the day the following activities can be performed: (<b>O</b>ccasional 1-33% or .5-2.5 hrs. <b>F</b>requent 34-66% or 2.6-5.0 hrs. <b>C</b>ontinuous 67-100% or 5.1-8 hrs. or <b>N</b>ever)</p> <table style="width:100%;"> <tr> <td style="width:50%; vertical-align: top;"> <div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div> </td> <td style="width:50%; vertical-align: top;"> <div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div> </td> </tr> <tr> <td style="vertical-align: top;"> Climbing - Crawling Kneeling Lifting Pulling Pushing Reaching above shoulder Forward reaching Carrying Bending Twisting </td> <td style="vertical-align: top;"> Hand Grasping __R__L Firm Hand Grasping __R__L Fine Manipulation __R__L Gross Manipulation __R__L Repetitive Motion __R__L Sitting __R__L Standing __R__L Stooping __R__L Walking __R__L Other _____ </td> </tr> </table>				<div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>	<div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>	Climbing - Crawling Kneeling Lifting Pulling Pushing Reaching above shoulder Forward reaching Carrying Bending Twisting	Hand Grasping __R__L Firm Hand Grasping __R__L Fine Manipulation __R__L Gross Manipulation __R__L Repetitive Motion __R__L Sitting __R__L Standing __R__L Stooping __R__L Walking __R__L Other _____				
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Heat Cold Dampness Noise	Dust Fumes Chemicals Radiation										
Limitations to: Speaking _____ hrs. Vision (explain) _____ Depth Perception _____ Hearing (explain) _____											
Total # of hours patient capable of working per day: 12 <input type="checkbox"/> 8 <input type="checkbox"/> 6 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> Duration of restrictions: _____ Care Complete: Yes <input type="checkbox"/> No <input type="checkbox"/> Next Appointment: _____ Additional Comments: _____ _____ _____											
Physician's Signature			Date (MM/DD/YYYY)								
Physician Name		Specialty									
Phone Number		Fax Number									
Address											

WKAB  
GC-1500-26 (7-13)

Page 1 of 2





Claim Number: 9452367

Employee Name (Last, First Middle Initial) Required  
DAVIS, ARTHUR

### Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Employee's Signature

Date (MM/DD/YYYY)







PO Box 14560  
Lexington, KY 40512-4560  
SHAWNDR A LEE  
STD BENEFIT MANAGER  
Phone: 800-354-1779  
Fax: 1-866-667-1987

06/16/2014

Premier Orthopaedics & Sports  
394 Harding Place  
Nashville TN - 37211

Group Control No: 0476626  
Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

To Whom It May Concern:

The Dell Inc. group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna). To properly evaluate their eligibility for continued disability benefits, information is needed from your office.

Please include current office and/or chart notes, along with any medical documentation you may have including, labs, blood work, physical exam, MRI/x-ray, and the results of any other diagnostic test from the last 3 office visit. We also ask that you complete the attached Attending Physician Statement and Capabilities and Limitations Work Sheet.

Dell Inc.'s Program requires a clinical review of the medical appropriateness for your patient's work absence. Your office can fax the documents to 1-866-667-1987 or mail them to:

Aetna Life Insurance Company  
Dell Inc. LTD Program  
PO Box 14560  
Lexington, KY 40512-4560

It is important to understand that if we do not receive the requested documentation by July 1, 2014 your patient's case may be closed and benefits may be terminated.

Should you have any questions regarding your claim, please call 800-354-1779 and an Aetna Customer Service Representative will be happy to assist you.

Sincerely,

Wanda Greene Celestine  
Senior Technical Specialist  
Aetna Life Insurance Company

Enclosures:  
Attending Physician Statement  
Capabilities and Limitations Worksheet

Claim Number: 9452367



## Attending Physician Statement

Complete and sign the form using **BLUE** or **BLACK** ink.

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

- 1. Patient Instructions** – The Physician will complete Sections 2 through 7.  
The Patient will complete Sections 1 and 8.  
The Patient should also fill in their name at the top of Pages 2 and 3.

The **Patient** is responsible for completing this section and for **ensuring** that their **Attending Physician completes the remainder of this statement**. The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. **If you have any questions, please call 800-354-1779.**

(a) Control Number 0476626

(b) DAVIS, ARTHUR / REDACTED / REDACTED / REDACTED / REDACTED  
Patient Name (Last, First, Middle Initial) Social Security Number Year of Birth Height Weight (lbs)

(c) Patient Gender ☐ Male ☐ Female

(d) Patient Home Address – Required (Current No., Street, Town, State, ZIP – no PO boxes) ☐ Check if New

(e) Mailing Address, if different from Home Address \_\_\_\_\_

(f) Patient Employer Name/City/State Dell Inc

(g) Patient Telephone Number \_\_\_\_\_ ☐ Check if New

(h) Job Title/Occupation Inside Sales Account Mgmt lii

(i) Type of Claim: ☐ Short Term Disability ☐ Long Term Disability ☐ Waiver of Premium  
☐ Long Term / Permanent Total Disability

### 2. Physician Instructions

The **Attending Physician** should **complete the items below**, based upon a **recent examination**. Attach additional documentation as needed. If you have any questions, please call **800-354-1779**.  
**Please complete form in its entirety and fax to 1-866-667-1987. Pages 2 and 3 MUST be completed before faxing.**

### 3. Impairing Diagnosis & Treatment

(a) For medical reasons, the patient will need to be absent from work due to a disability beginning on MM/DD/YYYY and ending on MM/DD/YYYY.

(b) Primary Diagnosis \_\_\_\_\_ Primary ICD Code \_\_\_\_\_  
Secondary Diagnosis \_\_\_\_\_ Secondary ICD Code \_\_\_\_\_  
Other Diagnoses \_\_\_\_\_ Other ICD Codes \_\_\_\_\_

(c) Height \_\_\_\_\_ Weight \_\_\_\_\_ Date Measured (MM/DD/YYYY) \_\_\_\_\_

(d) If Pregnancy related, delivery or expected due date Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Delivery Type: ☐ Vaginal ☐ Cesarean

(e) Surgery Date \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Primary Procedure \_\_\_\_\_ Primary CPT Code \_\_\_\_\_  
Secondary Procedure \_\_\_\_\_ Secondary CPT Code \_\_\_\_\_  
Other Procedures \_\_\_\_\_ Other CPT Codes \_\_\_\_\_

(f) Medication(s)/Dose/Frequency \_\_\_\_\_  
Impairment from medication effects \_\_\_\_\_

(g) Is patient still under your care for this condition? ☐ Yes ☐ No Date service terminated MM/DD/YYYY

(h) Treatment Summary \_\_\_\_\_

(i) Office Visit Dates: First MM/DD/YYYY Last MM/DD/YYYY Next MM/DD/YYYY Frequency of appointments \_\_\_\_\_

(j) Was patient recently hospitalized? ☐ No ☐ Yes Date hospitalized: Admit MM/DD/YYYY Discharge MM/DD/YYYY

(k) Hospital Name/City/State \_\_\_\_\_

WKAB- GC-1486-26 (7-13) C R-POD



Patient Name (Last, First, Middle Initial) **Required**

DAVIS, ARTHUR

**4. History**

- (a) Symptoms: \_\_\_\_\_
- (b) Date symptoms first appeared or accident happened Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- (c) Has patient ever had same or similar condition? ☐ No ☐ Yes State when and describe. \_\_\_\_\_
- (e) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown
- (f) Other Treating Physicians
- Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_
- Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**5. Abilities/Limitations**

- (a) **Patient is: Place remarks in item (d) below, if applicable.**
- Competent to endorse checks and direct the use of proceeds thereof .... ☐ Yes ☐ No ☐ Other/describe in (d)
  - Able to work with others ..... ☐ Yes ☐ No ☐ Other/describe in (d)
  - Able to give supervision ..... ☐ Yes ☐ No ☐ Other/describe in (d)
  - Able to work cooperatively with others in group setting ..... ☐ Yes ☐ No ☐ Other/describe in (d)
  - Able to do? **Select one: Place remarks in item (d) below, if applicable.**
    - ☐ **Heavy work** activity. No limitations of functional capacity.
    - ☐ **Medium work** activity. Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly.
    - ☐ **Light work** activity. Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently.
    - ☐ **Sedentary work** activity. Moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. (Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.)
    - ☐ **No ability to work.** Severe limitation of functional capacity; incapable of minimal activity.
    - ☐ **Other.** Place remarks in item (d) below.
- (b) **What medical restrictions/limitations are you placing on patient? (Activities of Daily Living, Driving, Lifting, Pulling, Pushing, and Amounts, etc.)** \_\_\_\_\_
- \_\_\_\_\_
- Number of Hours patient is capable of working in a day: ☐ 12 ☐ 10 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐ 1 Hour/Day
- Number of Days per week patient is able to work: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week
- Date you prescribed restriction on work activities: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- How long are these restrictions/limitations in effect? \_\_\_\_\_ ☐ No Longer
- Days Weeks Months
- Estimated return to work date? \_\_\_\_\_ Modified Duty \_\_\_\_\_ Full Duty \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)
- (c) **Objective findings that substantiate impairment** (current laboratory, physical and/or mental status examination and other testing) \_\_\_\_\_
- (d) Other/Comments \_\_\_\_\_

**6. Current Status**

- (a) Patient has ☐ Improved ☐ Stabilized ☐ Regressed ☐ Not Applicable
- (b) Is there a medical contraindication for patient to participate in Vocational Rehabilitation (job training) programs?  
☐ No ☐ Yes, please explain \_\_\_\_\_
- (c) In your opinion, is your patient motivated to return to work? \_\_\_\_\_

**7. Physician Information**

Attending Physician's Name ( <i>Print</i> )	Degree	Specialty
Address (No. Street, City, State, ZIP Code)	Telephone Number	Fax Number
Signature		Date (MM/DD/YYYY)

WKAB

GC-1486-26 (7-13) C



Claim Number: 9452367

Patient Name (Last, First, Middle Initial) **Required**  
DAVIS, ARTHUR

#### 8. Regulation Notice

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WKAB  
GC-1486-26 (7-13) C

Pa



Claim Number: 9452367



# Capabilities and Limitations Worksheet

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

Employee Name (Last, First, Middle Initial) <b>DAVIS, ARTHUR</b>		Social Security Number	Year of Birth				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Job Title		Control Number <b>0476626</b>				
Current Diagnosis		Medications:					
<p>Indicate the percent of the day the following activities can be performed: (<b>O</b>ccasional 1-33% or .5-2.5 hrs. <b>F</b>requent 34-66% or 2.6-5.0 hrs. <b>C</b>ontinuous 67-100% or 5.1-8 hrs. or <b>N</b>ever)</p> <table style="width:100%;"> <tr> <td style="width:50%; vertical-align: top;"> <div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div> </td> <td style="width:50%; vertical-align: top;"> <div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div> </td> </tr> <tr> <td style="vertical-align: top;"> Climbing - Crawling Kneeling Lifting Pulling Pushing Reaching above shoulder Forward reaching Carrying Bending Twisting </td> <td style="vertical-align: top;"> Hand Grasping __R__L Firm Hand Grasping __R__L Fine Manipulation __R__L Gross Manipulation __R__L Repetitive Motion __R__L Sitting __R__L Standing __R__L Stooping __R__L Walking __R__L Other _____ </td> </tr> </table>				<div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>	<div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>	Climbing - Crawling Kneeling Lifting Pulling Pushing Reaching above shoulder Forward reaching Carrying Bending Twisting	Hand Grasping __R__L Firm Hand Grasping __R__L Fine Manipulation __R__L Gross Manipulation __R__L Repetitive Motion __R__L Sitting __R__L Standing __R__L Stooping __R__L Walking __R__L Other _____
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Physician's Signature			Date (MM/DD/YYYY)				
Physician Name		Specialty					
Phone Number		Fax Number					
Address							



Claim Number: 9452367

Employee Name (Last, First Middle Initial) Required  
DAVIS, ARTHUR

### Misrepresentation

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Employee's Signature

Date (MM/DD/YYYY)









PO Box 14560  
Lexington, KY 40512-4560  
SHAWNDR A LEE  
STD BENEFIT MANAGER  
Phone: 800-354-1779  
Fax: 1-866-667-1987

06/16/2014

Dr. SUBIR PRASAD  
4230 HARDING RD , SUITE 805E  
NASHVILLE TN - 37205

Group Control No: 0476626  
Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

Dear Dr. Prasad:

The Dell Inc. group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna). To properly evaluate their eligibility for continued disability benefits, information is needed from your office.

Please include current office and/or chart notes, along with any medical documentation you may have including, labs, blood work, physical exam, MRI/x-ray, and the results of any other diagnostic test from the last 3 office visit. We also ask that you complete the attached Attending Physician Statement and Capabilities and Limitations Work Sheet.

Dell Inc.'s Program requires a clinical review of the medical appropriateness for your patient's work absence. Your office can fax the documents to 1-866-667-1987 or mail them to:

Aetna Life Insurance Company  
Dell Inc. LTD Program  
PO Box 14560  
Lexington, KY 40512-4560

It is important to understand that if we do not receive the requested documentation by July 1, 2014 your patient's case may be closed and benefits may be terminated.

Should you have any questions regarding your claim, please call 800-354-1779 and an Aetna Customer Service Representative will be happy to assist you.

Sincerely,

Wanda Greene Celestine  
Senior Technical Specialist  
Aetna Life Insurance Company

Enclosures:  
Attending Physician Statement  
Capabilities and Limitations Worksheet

Claim Number: 9452367



## Attending Physician Statement

Complete and sign the form using **BLUE** or **BLACK** ink.

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

- 1. Patient Instructions** – The Physician will complete Sections 2 through 7.  
The Patient will complete Sections 1 and 8.  
The Patient should also fill in their name at the top of Pages 2 and 3.

The **Patient** is responsible for completing this section and for **ensuring** that their **Attending Physician completes the remainder of this statement**. The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. **If you have any questions, please call 800-354-1779.**

(a) Control Number 0476626

(b) DAVIS, ARTHUR / REDACTED / REDACTED / REDACTED / REDACTED  
Patient Name (Last, First, Middle Initial) Social Security Number Year of Birth Height Weight (lbs)

(c) Patient Gender ☐ Male ☐ Female

(d) Patient Home Address – Required (Current No., Street, Town, State, ZIP – no PO boxes) ☐ Check if New

(e) Mailing Address, if different from Home Address \_\_\_\_\_

(f) Patient Employer Name/City/State Dell Inc

(g) Patient Telephone Number \_\_\_\_\_ ☐ Check if New

(h) Job Title/Occupation Inside Sales Account Mgmt lii

(i) Type of Claim: ☐ Short Term Disability ☐ Long Term Disability ☐ Waiver of Premium  
☐ Long Term / Permanent Total Disability

### 2. Physician Instructions

The **Attending Physician** should **complete the items below**, based upon a **recent examination**. Attach additional documentation as needed. If you have any questions, please call **800-354-1779**.  
**Please complete form in its entirety and fax to 1-866-667-1987. Pages 2 and 3 MUST be completed before faxing.**

### 3. Impairing Diagnosis & Treatment

(a) **For medical reasons, the patient will need to be absent from work due to a disability beginning on** MM/DD/YYYY **and ending on** MM/DD/YYYY.

(b) Primary Diagnosis \_\_\_\_\_ Primary ICD Code \_\_\_\_\_  
Secondary Diagnosis \_\_\_\_\_ Secondary ICD Code \_\_\_\_\_  
Other Diagnoses \_\_\_\_\_ Other ICD Codes \_\_\_\_\_

(c) Height \_\_\_\_\_ Weight \_\_\_\_\_ Date Measured (MM/DD/YYYY) \_\_\_\_\_

(d) If Pregnancy related, delivery or expected due date Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Delivery Type: ☐ Vaginal ☐ Cesarean

(e) Surgery Date \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Primary Procedure \_\_\_\_\_ Primary CPT Code \_\_\_\_\_  
Secondary Procedure \_\_\_\_\_ Secondary CPT Code \_\_\_\_\_  
Other Procedures \_\_\_\_\_ Other CPT Codes \_\_\_\_\_

(f) Medication(s)/Dose/Frequency \_\_\_\_\_  
Impairment from medication effects \_\_\_\_\_

(g) Is patient still under your care for this condition? ☐ Yes ☐ No Date service terminated \_\_\_\_\_  
(MM/DD/YYYY)

(h) Treatment Summary \_\_\_\_\_

(i) Office Visit Dates: First \_\_\_\_\_ Last \_\_\_\_\_ Next \_\_\_\_\_ Frequency of appointments \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY) (MM/DD/YYYY)

(j) Was patient recently hospitalized? ☐ No ☐ Yes Date hospitalized: Admit \_\_\_\_\_ Discharge \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

(k) Hospital Name/City/State \_\_\_\_\_

WKAB- GC-1486-26 (7-13) C R-POD



Patient Name (Last, First, Middle Initial) **Required**

DAVIS, ARTHUR

**4. History**

(a) Symptoms: \_\_\_\_\_

(b) Date symptoms first appeared or accident happened Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

(c) Has patient ever had same or similar condition? ☐ No ☐ Yes State when and describe. \_\_\_\_\_

(e) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown

(f) Other Treating Physicians

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**5. Abilities/Limitations**

(a) **Patient is: Place remarks in item (d) below, if applicable.**

- Competent to endorse checks and direct the use of proceeds thereof .... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to work with others ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to give supervision ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to work cooperatively with others in group setting ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to do? **Select one: Place remarks in item (d) below, if applicable.**
  - ☐ **Heavy work** activity. No limitations of functional capacity.
  - ☐ **Medium work** activity. Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly.
  - ☐ **Light work** activity. Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently.
  - ☐ **Sedentary work** activity. Moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. (Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.)
  - ☐ **No ability to work.** Severe limitation of functional capacity; incapable of minimal activity.
  - ☐ **Other.** Place remarks in item (d) below.

(b) **What medical restrictions/limitations are you placing on patient? (Activities of Daily Living, Driving, Lifting, Pulling, Pushing, and Amounts, etc.)** \_\_\_\_\_

\_\_\_\_\_

• Number of Hours patient is capable of working in a day: ☐ 12 ☐ 10 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐ 1 Hour/Day

• Number of Days per week patient is able to work: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week

• Date you prescribed restriction on work activities: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

• How long are these restrictions/limitations in effect? \_\_\_\_\_ ☐ No Longer

Days Weeks Months

• Estimated return to work date? \_\_\_\_\_ Modified Duty \_\_\_\_\_ Full Duty \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

(c) **Objective findings that substantiate impairment** (current laboratory, physical and/or mental status examination and other testing) \_\_\_\_\_

(d) Other/Comments \_\_\_\_\_

**6. Current Status**

(a) Patient has ☐ Improved ☐ Stabilized ☐ Regressed ☐ Not Applicable

(b) Is there a medical contraindication for patient to participate in Vocational Rehabilitation (job training) programs?  
☐ No ☐ Yes, please explain \_\_\_\_\_

(c) In your opinion, is your patient motivated to return to work? \_\_\_\_\_

**7. Physician Information**

Attending Physician's Name ( <i>Print</i> )	Degree	Specialty
Address (No. Street, City, State, ZIP Code)	Telephone Number	Fax Number
Signature		Date (MM/DD/YYYY)

WKAB

GC-1486-26 (7-13) C



Claim Number: 9452367

Patient Name (Last, First, Middle Initial) **Required**  
DAVIS, ARTHUR

#### 8. Regulation Notice

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WKAB  
GC-1486-26 (7-13) C

Pa



Claim Number: 9452367



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Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

Employee Name (Last, First, Middle Initial) <b>DAVIS, ARTHUR</b>		Social Security Number	Year of Birth				
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Physician's Signature			Date (MM/DD/YYYY)				
Physician Name		Specialty					
Phone Number		Fax Number					
Address							

WKAB  
GC-1500-26 (7-13)

Page 1 of 2



Claim Number: 9452367

Employee Name (Last, First Middle Initial) Required  
DAVIS, ARTHUR

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PO Box 14560  
Lexington, KY 40512-4560  
SHAWNDR A LEE  
STD BENEFIT MANAGER  
Phone: 800-354-1779  
Fax: 1-866-667-1987

06/16/2014

Dr. Jason Knox  
300 STONECREST BLVD , SUITE 450  
SMYRNA TN - 37167

Group Control No: 0476626  
Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

Dear Dr. Knox:

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Sincerely,

Wanda Greene Celestine  
Senior Technical Specialist  
Aetna Life Insurance Company

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Attending Physician Statement  
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**aetna®**

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Lexington, KY 40512-4560  
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(a) Control Number 0476626

(b) DAVIS, ARTHUR / [REDACTED] /            /            /             
Patient Name (Last, First, Middle Initial) Social Security Number Year of Birth Height Weight (lbs)

(c) Patient Gender ☐ Male ☐ Female

(d) \_\_\_\_\_  
Patient Home Address – Required (Current No., Street, Town, State, ZIP – no PO boxes) ☐ Check if New

(e) Mailing Address, if different from Home Address \_\_\_\_\_

(f) Patient Employer Name/City/State Dell Inc

(g) Patient Telephone Number \_\_\_\_\_ ☐ Check if New

(h) Job Title/Occupation Inside Sales Account Mgmt Iii

(i) Type of Claim: ☐ Short Term Disability ☐ Long Term Disability ☐ Waiver of Premium  
☐ Long Term / Permanent Total Disability

The **Attending Physician** should **complete the items below**, based upon a **recent examination**. Attach additional documentation as needed. If you have any questions, please call **800-354-1779**.

**Please complete form in its entirety and fax to 1-866-667-1987.** **Pages 2 and 3 MUST be completed before faxing**

(a) **For medical reasons, the patient will need to be absent from work due to a disability beginning on \_\_\_\_\_ and ending on \_\_\_\_\_.**  
(MM/DD/YYYY) (MM/DD/YYYY)

(b) Primary Diagnosis \_\_\_\_\_ Primary ICD Code \_\_\_\_\_  
Secondary Diagnosis \_\_\_\_\_ Secondary ICD Code \_\_\_\_\_  
Other Diagnoses \_\_\_\_\_ Other ICD Codes \_\_\_\_\_

(c) Height \_\_\_\_\_ Weight \_\_\_\_\_ Date Measured (MM/DD/YYYY) \_\_\_\_\_

(d) If Pregnancy related, delivery or expected due date Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Delivery Type: ☐ Vaginal ☐ Cesarean

(e) Surgery Date \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Primary Procedure \_\_\_\_\_ Primary CPT Code \_\_\_\_\_  
Secondary Procedure \_\_\_\_\_ Secondary CPT Code \_\_\_\_\_  
Other Procedures \_\_\_\_\_ Other CPT Codes \_\_\_\_\_

(f) Medication(s)/Dose/Frequency \_\_\_\_\_  
Impairment from medication effects \_\_\_\_\_

(g) Is patient still under your care for this condition? ☐ Yes ☐ No Date service terminated \_\_\_\_\_  
(MM/DD/YYYY)

(h) Treatment Summary \_\_\_\_\_

(i) Office Visit Dates: First \_\_\_\_\_ Last \_\_\_\_\_ Next \_\_\_\_\_ Frequency of appointments \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY) (MM/DD/YYYY)

(j) Was patient recently hospitalized? ☐ No ☐ Yes Date hospitalized: Admit \_\_\_\_\_ Discharge \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

(k) Hospital Name/City/State \_\_\_\_\_



Patient Name (Last, First, Middle Initial) **Required**

DAVIS, ARTHUR

**4. History**

(a) Symptoms: \_\_\_\_\_

(b) Date symptoms first appeared or accident happened Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

(c) Has patient ever had same or similar condition? ☐ No ☐ Yes State when and describe. \_\_\_\_\_

(e) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown

(f) Other Treating Physicians

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**5. Abilities/Limitations**

(a) **Patient is: Place remarks in item (d) below, if applicable.**

- Competent to endorse checks and direct the use of proceeds thereof .... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to work with others ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to give supervision ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to work cooperatively with others in group setting ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to do? **Select one: Place remarks in item (d) below, if applicable.**
  - ☐ **Heavy work** activity. No limitations of functional capacity.
  - ☐ **Medium work** activity. Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly.
  - ☐ **Light work** activity. Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently.
  - ☐ **Sedentary work** activity. Moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. (Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.)
  - ☐ **No ability to work.** Severe limitation of functional capacity; incapable of minimal activity.
  - ☐ **Other.** Place remarks in item (d) below.

(b) **What medical restrictions/limitations are you placing on patient? (Activities of Daily Living, Driving, Lifting, Pulling, Pushing, and Amounts, etc.)** \_\_\_\_\_

\_\_\_\_\_

• Number of Hours patient is capable of working in a day: ☐ 12 ☐ 10 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐ 1 Hour/Day

• Number of Days per week patient is able to work: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week

• Date you prescribed restriction on work activities: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

• How long are these restrictions/limitations in effect? \_\_\_\_\_ ☐ No Longer

Days Weeks Months

• Estimated return to work date? \_\_\_\_\_ Modified Duty \_\_\_\_\_ Full Duty

(MM/DD/YYYY) (MM/DD/YYYY)

(c) **Objective findings that substantiate impairment** (current laboratory, physical and/or mental status examination and other testing) \_\_\_\_\_

\_\_\_\_\_

(d) Other/Comments \_\_\_\_\_

\_\_\_\_\_

**6. Current Status**

(a) Patient has ☐ Improved ☐ Stabilized ☐ Regressed ☐ Not Applicable

(b) Is there a medical contraindication for patient to participate in Vocational Rehabilitation (job training) programs?  
☐ No ☐ Yes, please explain \_\_\_\_\_

(c) In your opinion, is your patient motivated to return to work? \_\_\_\_\_

**7. Physician Information**

Attending Physician's Name ( <i>Print</i> )	Degree	Specialty
Address (No. Street, City, State, ZIP Code)	Telephone Number	Fax Number
Signature		Date (MM/DD/YYYY)

WKAB

GC-1486-26 (7-13) C



Claim Number: 9452367

Patient Name (Last, First, Middle Initial) **Required**  
DAVIS, ARTHUR

#### 8. Regulation Notice

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

WKAB  
GC-1486-26 (7-13) C

Pa



Claim Number: 9452367



# Capabilities and Limitations Worksheet

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

Employee Name (Last, First, Middle Initial) <b>DAVIS, ARTHUR</b>		Social Security Number	Year of Birth				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Job Title		Control Number <b>0476626</b>				
Current Diagnosis		Medications:					
<p>Indicate the percent of the day the following activities can be performed: (<b>O</b>ccasional 1-33% or .5-2.5 hrs. <b>F</b>requent 34-66% or 2.6-5.0 hrs. <b>C</b>ontinuous 67-100% or 5.1-8 hrs. or <b>N</b>ever)</p> <table style="width:100%;"> <tr> <td style="width:50%; vertical-align: top;"> <div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div> </td> <td style="width:50%; vertical-align: top;"> <div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div> </td> </tr> <tr> <td style="vertical-align: top;"> Climbing - <input type="checkbox"/>  Crawling <input type="checkbox"/>  Kneeling <input type="checkbox"/>  Lifting <input type="checkbox"/>  Pulling <input type="checkbox"/>  Pushing <input type="checkbox"/>  Reaching above shoulder <input type="checkbox"/>  Forward reaching <input type="checkbox"/>  Carrying <input type="checkbox"/>  Bending <input type="checkbox"/>  Twisting <input type="checkbox"/> </td> <td style="vertical-align: top;"> Hand Grasping <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b>  Firm Hand Grasping <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b>  Fine Manipulation <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b>  Gross Manipulation <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b>  Repetitive Motion <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b>  Sitting <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b>  Standing <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b>  Stooping <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b>  Walking <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b>  Other _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </td> </tr> </table>				<div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>	<div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>	Climbing - <input type="checkbox"/> Crawling <input type="checkbox"/> Kneeling <input type="checkbox"/> Lifting <input type="checkbox"/> Pulling <input type="checkbox"/> Pushing <input type="checkbox"/> Reaching above shoulder <input type="checkbox"/> Forward reaching <input type="checkbox"/> Carrying <input type="checkbox"/> Bending <input type="checkbox"/> Twisting <input type="checkbox"/>	Hand Grasping <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b> Firm Hand Grasping <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b> Fine Manipulation <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b> Gross Manipulation <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b> Repetitive Motion <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b> Sitting <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b> Standing <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b> Stooping <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b> Walking <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>L</b> Other _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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Maximum weight patient is capable of lifting: <div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>		Approved Head and Neck Movements: <div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>					
1 - 5 lbs. <input type="checkbox"/> 6 - 10 lbs. <input type="checkbox"/> 11 - 20 lbs. <input type="checkbox"/> 21 - 35 lbs. <input type="checkbox"/> 36 - 50 lbs. <input type="checkbox"/> 51 - 75 lbs. <input type="checkbox"/> 75 - 100 lbs. <input type="checkbox"/> 100 lbs. + <input type="checkbox"/>		Can the Patient operate: <div style="display: flex; justify-content: space-between;"><div><b>O</b></div><div><b>F</b></div><div><b>C</b></div><div><b>N</b></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div><div><input type="checkbox"/></div></div>					
Limitations to: Speaking _____ hrs. Vision (explain) _____ Depth Perception _____ Hearing (explain) _____		Exposure Limitations: Yes No Yes No Heat <input type="checkbox"/> <input type="checkbox"/> Dust <input type="checkbox"/> <input type="checkbox"/> Cold <input type="checkbox"/> <input type="checkbox"/> Fumes <input type="checkbox"/> <input type="checkbox"/> Dampness <input type="checkbox"/> <input type="checkbox"/> Chemicals <input type="checkbox"/> <input type="checkbox"/> Noise <input type="checkbox"/> <input type="checkbox"/> Radiation <input type="checkbox"/> <input type="checkbox"/>					
Total # of hours patient capable of working per day: 12 <input type="checkbox"/> 8 <input type="checkbox"/> 6 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> Duration of restrictions: _____ Care Complete: Yes <input type="checkbox"/> No <input type="checkbox"/> Next Appointment: _____ Additional Comments: _____ _____ _____							
Physician's Signature		Date (MM/DD/YYYY)					
Physician Name		Specialty					
Phone Number		Fax Number					
Address							



Claim Number: 9452367

Employee Name (Last, First Middle Initial) Required  
DAVIS, ARTHUR

### Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Employee's Signature

Date (MM/DD/YYYY)







PO Box 14560  
Lexington, KY 40512-4560  
800-354-1779

LEE

# **Facsimile Transmittal Sheet**

To:		From:
Dr. Subir Prasad		Aetna Disability
Employer:		Date:
Dell Inc		06/20/2014
Fax Number: 615-916-3953		CLAIM NUMBER:
		9452367
Phone number:		Sender's Phone Number:
615-425-7605		800-354-1779
		Sender's FAX Number:
		1-866-667-1987
Re: MR. ARTHUR DAVIS		Total No. of Pages Including Cover: 5
Date of Birth: REDACTED		

Urgent    For Review    Please Comment    Please Reply    Please Recycle

Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

## **Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you received this communication in error, please notify the sender at the phone number above.

## **NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

The information contained in this document is CONFIDENTIAL. If you have received this in error, please fax immediately to 1-866-667-1987. Thank you.

## **Enclosed:**

Attending Physician Statement  
Capabilities and Limitations Worksheet



Claim Number: 9452367



## Attending Physician Statement

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: 800-354-1779  
Fax: 1-866-667-1987

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

- 1. Patient Instructions** – The Physician will complete Sections 2 through 7.  
The Patient will complete Sections 1 and 8.  
The Patient should also fill in their name at the top of Pages 2 and 3.

The **Patient** is responsible for completing this section and for **ensuring** that their **Attending Physician completes the remainder of this statement**. The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. **If you have any questions, please call 800-354-1779.**

- (a) Control Number 0476626
- (b) DAVIS, ARTHUR / REDACTED / REDACTED / REDACTED / REDACTED  
Patient Name (Last, First, Middle Initial) Social Security Number Year of Birth Height Weight (lbs)
- (c) Patient Gender ☐ Male ☐ Female
- (d) Patient Home Address – Required (Current No., Street, Town, State, ZIP – no PO boxes) ☐ Check if New
- (e) Mailing Address, if different from Home Address \_\_\_\_\_
- (f) Patient Employer Name/City/State Dell Inc
- (g) Patient Telephone Number \_\_\_\_\_ ☐ Check if New
- (h) Job Title/Occupation Inside Sales Account Mgmt Iii
- (i) Type of Claim: ☐ Short Term Disability ☐ Long Term Disability ☐ Waiver of Premium  
☐ Long Term / Permanent Total Disability

## 2. Physician Instructions

The **Attending Physician** should **complete the items below**, based upon a **recent examination**. Attach additional documentation as needed. If you have any questions, please call 800-354-1779.

**Please complete form in its entirety and fax to 1-866-667-1987.**

**Pages 2 and 3 MUST be completed before faxing.**

## 3. Impairing Diagnosis & Treatment

- (a) **For medical reasons, the patient will need to be absent from work due to a disability beginning on** \_\_\_\_\_ **and ending on** \_\_\_\_\_ .  
(MM/DD/YYYY) (MM/DD/YYYY)
- (b) Primary Diagnosis \_\_\_\_\_ Primary ICD Code \_\_\_\_\_  
Secondary Diagnosis \_\_\_\_\_ Secondary ICD Code \_\_\_\_\_  
Other Diagnoses \_\_\_\_\_ Other ICD Codes \_\_\_\_\_
- (c) Height \_\_\_\_\_ Weight \_\_\_\_\_ Date Measured (MM/DD/YYYY) \_\_\_\_\_
- (d) If Pregnancy related, delivery or expected due date \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Delivery Type: ☐ Vaginal ☐ Cesarean
- (e) Surgery Date \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Primary Procedure \_\_\_\_\_ Primary CPT Code \_\_\_\_\_  
Secondary Procedure \_\_\_\_\_ Secondary CPT Code \_\_\_\_\_  
Other Procedures \_\_\_\_\_ Other CPT Codes \_\_\_\_\_
- (f) Medication(s)/Dose/Frequency \_\_\_\_\_  
Impairment from medication effects \_\_\_\_\_
- (g) Is patient still under your care for this condition? ☐ Yes ☐ No Date service terminated \_\_\_\_\_  
(MM/DD/YYYY)
- (h) Treatment Summary \_\_\_\_\_
- (i) Office Visit Dates: First \_\_\_\_\_ Last \_\_\_\_\_ Next \_\_\_\_\_ Frequency of appointments \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY) (MM/DD/YYYY)
- (j) Was patient recently hospitalized? ☐ No ☐ Yes Date hospitalized: Admit \_\_\_\_\_ Discharge \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)
- (k) Hospital Name/City/State \_\_\_\_\_

WKAB- GC-1486-26 (7-13) C R-POD



Patient Name (Last, First, Middle Initial) Required

DAVIS, ARTHUR

**4. History**

- (a) Symptoms: \_\_\_\_\_
- (b) Date symptoms first appeared or accident happened Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- (c) Has patient ever had same or similar condition? ☐ No ☐ Yes State when and describe. \_\_\_\_\_
- (e) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown
- (f) Other Treating Physicians
- Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_
- Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**5. Abilities/Limitations**

- (a) **Patient is: Place remarks in item (d) below, if applicable.**
- Competent to endorse checks and direct the use of proceeds thereof .... ☐ Yes ☐ No ☐ Other/describe in (d)
  - Able to work with others ..... ☐ Yes ☐ No ☐ Other/describe in (d)
  - Able to give supervision ..... ☐ Yes ☐ No ☐ Other/describe in (d)
  - Able to work cooperatively with others in group setting ..... ☐ Yes ☐ No ☐ Other/describe in (d)
  - Able to do? **Select one: Place remarks in item (d) below, if applicable.**
    - ☐ **Heavy work** activity. No limitations of functional capacity.
    - ☐ **Medium work** activity. Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly.
    - ☐ **Light work** activity. Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently.
    - ☐ **Sedentary work** activity. Moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. (Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.)
    - ☐ **No ability to work.** Severe limitation of functional capacity; incapable of minimal activity.
    - ☐ **Other.** Place remarks in item (d) below.
- (b) **What medical restrictions/limitations are you placing on patient? (Activities of Daily Living, Driving, Lifting, Pulling, Pushing, and Amounts, etc.)** \_\_\_\_\_
- \_\_\_\_\_
- Number of Hours patient is capable of working in a day: ☐ 12 ☐ 10 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐ 1 Hour/Day
  - Number of Days per week patient is able to work: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week
  - Date you prescribed restriction on work activities: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
  - How long are these restrictions/limitations in effect? \_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months ☐ No Longer
  - Estimated return to work date? \_\_\_\_\_ Modified Duty \_\_\_\_\_ Full Duty \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)
- (c) **Objective findings that substantiate impairment** (current laboratory, physical and/or mental status examination and other testing) \_\_\_\_\_
- (d) Other/Comments \_\_\_\_\_

**6. Current Status**

- (a) Patient has ☐ Improved ☐ Stabilized ☐ Regressed ☐ Not Applicable
- (b) Is there a medical contraindication for patient to participate in Vocational Rehabilitation (job training) programs?  
☐ No ☐ Yes, please explain \_\_\_\_\_
- (c) In your opinion, is your patient motivated to return to work? \_\_\_\_\_

**7. Physician Information**

Attending Physician's Name ( <i>Print</i> )	Degree	Specialty
Address (No. Street, City, State, ZIP Code)	Telephone Number	Fax Number
Signature		Date (MM/DD/YYYY)

WKAB

GC-1486-26 (7-13) C



Claim Number: 9452367

Patient Name (Last, First, Middle Initial) Required DAVIS, ARTHUR
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#### 8. Regulation Notice

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

WKAB  
GC-1486-26 (7-13) C

Pa



Claim Number: 9452367



## Capabilities and Limitations Worksheet

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

Employee Name (Last, First, Middle Initial) <b>DAVIS, ARTHUR</b>		Social Security Number	Year of Birth							
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Job Title		Control Number <b>0476626</b>							
Current Diagnosis		Medications:								
Indicate the percent of the day the following activities can be performed: ( <b>O</b> ccasional 1-33% or .5-2.5 hrs. <b>F</b> requent 34-66% or 2.6-5.0 hrs. <b>C</b> ontinuous 67-100% or 5.1-8 hrs. or <b>N</b> ever)										
Climbing -	<b>O</b>	<b>F</b>	<b>C</b>	<b>N</b>	Hand Grasping __R__L	<b>O</b>	<b>F</b>	<b>C</b>	<b>N</b>	
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Firm Hand Grasping __R__L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fine Manipulation __R__L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gross Manipulation __R__L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repetitive Motion __R__L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting __R__L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reaching above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Standing __R__L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Forward reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stooping __R__L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walking __R__L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Maximum weight patient is capable of lifting:					Approved Head and Neck Movements:					
1 - 5 lbs.	<b>O</b>	<b>F</b>	<b>C</b>	<b>N</b>		Yes	No			
6 - 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Static Position	<input type="checkbox"/>	<input type="checkbox"/>			
11 - 20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Flexing	<input type="checkbox"/>	<input type="checkbox"/>			
21 - 35 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Rotation	<input type="checkbox"/>	<input type="checkbox"/>			
36 - 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can the Patient operate:					
51 - 75 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Yes	No			
75 - 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A Motor Vehicle	<input type="checkbox"/>	<input type="checkbox"/>			
100 lbs. +	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hazardous Machine	<input type="checkbox"/>	<input type="checkbox"/>			
					Power Tools	<input type="checkbox"/>	<input type="checkbox"/>			
Limitations to:					Exposure Limitations: Yes No					
Speaking _____ hrs.					Heat	<input type="checkbox"/>	<input type="checkbox"/>	Dust	<input type="checkbox"/>	<input type="checkbox"/>
Vision (explain) _____					Cold	<input type="checkbox"/>	<input type="checkbox"/>	Fumes	<input type="checkbox"/>	<input type="checkbox"/>
Depth Perception _____					Dampness	<input type="checkbox"/>	<input type="checkbox"/>	Chemicals	<input type="checkbox"/>	<input type="checkbox"/>
Hearing (explain) _____					Noise	<input type="checkbox"/>	<input type="checkbox"/>	Radiation	<input type="checkbox"/>	<input type="checkbox"/>
Total # of hours patient capable of working per day: 12 <input type="checkbox"/> 8 <input type="checkbox"/> 6 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/>										
Duration of restrictions: _____ Care Complete: Yes <input type="checkbox"/> No <input type="checkbox"/> Next Appointment: _____										
Additional Comments: _____										
_____										
_____										
_____										
Physician's Signature								Date (MM/DD/YYYY)		
Physician Name					Specialty					
Phone Number					Fax Number					
Address										



Claim Number: 9452367

Employee Name (Last, First Middle Initial) Required  
DAVIS, ARTHUR

### Misrepresentation

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Employee's Signature

Date (MM/DD/YYYY)







PO Box 14560  
Lexington, KY 40512-4560  
800-354-1779

LEE

# **Facsimile Transmittal Sheet**

To:		From:
Dr. SUBIR PRASAD		Aetna Disability
Employer:		Date:
Dell Inc		06/23/2014
Fax Number: 615-916-3953		CLAIM NUMBER:
		9452367
Phone number:		Sender's Phone Number:
		800-354-1779
		Sender's FAX Number:
		1-866-667-1987
Re: MR. ARTHUR DAVIS		Total No. of Pages Including Cover:
Date of Birth: REDACTED		
		6

Urgent   For Review   Please Comment   Please Reply   Please Recycle

Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

## **Disclaimer:**

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you received this communication in error, please notify the sender at the phone number above.

## **NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

The information contained in this document is CONFIDENTIAL. If you have received this in error, please fax immediately to 1-866-667-1987. Thank you.

## **Enclosed:**

Attending Physician Statement  
Capabilities and Limitations Worksheet

Claim Number: 9452367



## Attending Physician Statement

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

### 1. Patient Information

Name				Employer Name		Job Title	
Year of Birth	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No	Height (ft./in.)	Weight (lbs.)	BMI	Blood Pressure	Date Measured

### 2. Diagnostic Information

Primary Diagnosis	
ICD-9 Code(s)	DSM IV Code(s)
Complications	
Objective Findings	
Subjective Symptoms	
Are there any secondary conditions contributing to this conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what are they? _____	
Has this patient ever had the same condition or a similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what year(s)/describe? _____	

### 3. Treatment Information

Primary Diagnosis			First day recommended out of work
Date symptoms first appeared (or date of accident)	Date first treated for this condition	Most recent date treated for this condition	
Frequency with which you see this patient: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____ Provide date(s): _____			ICD9 code(s)
Has the patient undergone surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide date. _____	CPT code(s) & Procedure	Result
Do you expect surgery to be performed in the future? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide date. _____	Planned Procedure & CPT code	
Please list current medications with dosage and frequency.			
Please list other types and frequency of treatment.			
Is the patient a suitable candidate for vocational rehabilitation? <input type="checkbox"/> Yes <input type="checkbox"/> No		Please explain.	

### 4. Please list all treating or consulting physicians (include date of treatment as indicated).

a. Physician Name	Physician Telephone Number
Physician Address	Treatment Dates From: ____/____/____ To: ____/____/____
b. Physician Name	Physician Telephone Number
Physician Address	Treatment Dates From: ____/____/____ To: ____/____/____
c. Physician Name	Physician Telephone Number
Physician Full Address	Treatment Dates From: ____/____/____ To: ____/____/____

WKAB

GR-68337 (7-13)





Patient Name	Year of Birth
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**5. Please indicate any hospital / medical rehabilitation confinement for this patient, for this condition (include dates of confinement as indicated).**

a. Hospital / Facility Name	
Hospital / Facility Full Address	Treatment Dates From: ____ / ____ / ____ To: ____ / ____ / ____
b. Hospital / Facility Name	
Hospital / Facility Full Address	Treatment Dates From: ____ / ____ / ____ To: ____ / ____ / ____

**6. Progress**

Patient Status	
<input type="checkbox"/> Recovered	<input type="checkbox"/> Improved
<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Home Bound
<input type="checkbox"/> Unchanged	<input type="checkbox"/> Retrogressed
<input type="checkbox"/> Bed Confined	<input type="checkbox"/> Hospitalized
What is the prognosis?	
Has the patient achieved Maximum Medical Improvement? If No, how soon do you expect fundamental changes in the patient's medical condition:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1-2 months <input type="checkbox"/> 5-6 months <input type="checkbox"/> 3-4 months <input type="checkbox"/> More than 6 months
Please note any restrictions (activities your patient should not do).	
Please note any limitations (activities your patient cannot).	
Please describe any physical and/or MENTAL impairments.	
Date patient released from your care (if applicable). ____ / ____ / ____	Date patient able to return to full duty. ____ / ____ / ____

**7. Level of Impairment**

Physical Impairment (if applicable):	Mental/Nervous Impairment (if applicable):
<input type="checkbox"/> Class 1. No limitation of functional capacity/capable of heavy work.	<input type="checkbox"/> No Limitation: able to function under stress and engage in interpersonal relationships.
<input type="checkbox"/> Class 2. Slight limitation of functional capacity/capable of medium manual work	<input type="checkbox"/> Slight limitation: able to function in most stress situations and engage in most interpersonal relationships
<input type="checkbox"/> Class 3. Moderate limitation of functional capacity/capable of light work.	<input type="checkbox"/> Moderate limitation: able to engage in only limited stress and limited interpersonal relationships.
<input type="checkbox"/> Class 4. Marked limitation of functional capacity/capable of sedentary work.	<input type="checkbox"/> Marked limitation: unable to engage in stress or interpersonal relationships.
<input type="checkbox"/> Class 5. Severe limitation of functional capacity/incapable of sedentary work.	<input type="checkbox"/> Severe limitation: has significant loss of psychological, physiological, personal and social adjustment.
Cardiac Functional Capacity – NY Heart Association:	
<input type="checkbox"/> Class 1. No limitation <input type="checkbox"/> Class 2. Slight limitation <input type="checkbox"/> Class 3. Moderate limitation <input type="checkbox"/> Class 4. Complete limitation	
Do you believe your patient is competent to endorse checks and direct the use of the proceeds thereof?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Comments/Information	

**8. Attending Physician Information**

Physician's Signature	Date (MM/DD/YYYY) ____ / ____ / ____
Physician Name: _____	Specialty: _____
Phone Number: _____	Fax Number: _____
Address: _____	

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

WKAB- GR-68337 (7-13)



Claim Number: 9452367

Patient Name	Year of Birth
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#### 9. Misrepresentation

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WKAB  
GR-68337 (7-13)

Page 2



Claim Number: 9452367



# Capabilities and Limitations Worksheet

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Phone: **800-354-1779**  
Fax: **1-866-667-1987**

Employee Name (Last, First, Middle Initial) <b>DAVIS, ARTHUR</b>		Social Security Number	Year of Birth
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Job Title		Control Number <b>0476626</b>
Current Diagnosis		Medications:	
Indicate the percent of the day the following activities can be performed: ( <b>O</b> ccasional 1-33% or .5-2.5 hrs. <b>F</b> requent 34-66% or 2.6-5.0 hrs. <b>C</b> ontinuous 67-100% or 5.1-8 hrs. or <b>N</b> ever)			
Climbing -	<b>O</b>	<b>F</b>	<b>C</b>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forward reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand Grasping <u>  R  </u> <u>  L  </u>	<b>O</b>	<b>F</b>	<b>C</b>
Firm Hand Grasping <u>  R  </u> <u>  L  </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine Manipulation <u>  R  </u> <u>  L  </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gross Manipulation <u>  R  </u> <u>  L  </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repetitive Motion <u>  R  </u> <u>  L  </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting <u>  R  </u> <u>  L  </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing <u>  R  </u> <u>  L  </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stooping <u>  R  </u> <u>  L  </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking <u>  R  </u> <u>  L  </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other <u>                    </u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maximum weight patient is capable of lifting:		Approved Head and Neck Movements:	
1 - 5 lbs.	<b>O</b>	<b>F</b>	<b>C</b>
6 - 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 - 20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 - 35 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36 - 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 - 75 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75 - 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
100 lbs. +	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Static Position <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Frequent Flexing <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Frequent Rotation <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Can the Patient operate:	
		A Motor Vehicle <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Hazardous Machine <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Power Tools <input type="checkbox"/> Yes <input type="checkbox"/> No	
Limitations to:		Exposure Limitations: Yes No	
Speaking <u>          </u> hrs.		Heat <input type="checkbox"/> <input type="checkbox"/>	
Vision (explain) <u>                                    </u>		Cold <input type="checkbox"/> <input type="checkbox"/>	
Depth Perception <u>                                    </u>		Dampness <input type="checkbox"/> <input type="checkbox"/>	
Hearing (explain) <u>                                    </u>		Noise <input type="checkbox"/> <input type="checkbox"/>	
		Dust <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Fumes <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Chemicals <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Radiation <input type="checkbox"/> Yes <input type="checkbox"/> No	
Total # of hours patient capable of working per day: 12 <input type="checkbox"/> 8 <input type="checkbox"/> 6 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/>			
Duration of restrictions: <u>                                    </u> Care Complete: Yes <input type="checkbox"/> No <input type="checkbox"/> Next Appointment: <u>                                    </u>			
Additional Comments: <u>                                    </u>			
<u>                                    </u>			
<u>                                    </u>			
Physician's Signature		Date (MM/DD/YYYY)	
Physician Name		Specialty	
Phone Number		Fax Number	
Address			



Claim Number: 9452367

Employee Name (Last, First Middle Initial) Required  
DAVIS, ARTHUR

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Employee's Signature

Date (MM/DD/YYYY)





[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
07/14/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

We received your medical information for review on 07/10/2014. Your Claim Manager will notify you if any additional information is needed.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: [www.aetnadisability.com](http://www.aetnadisability.com)

[[EMAILSUBJECT: Response to your query]]**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
07/15/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

We forwarded your email to your Claim Manager to update her. She will contact you with any questions.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: [www.aetnadisability.com](http://www.aetnadisability.com)

[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
08/02/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: [www.aetnadisability.com](http://www.aetnadisability.com)



[[EMAILSUBJECT: Response to your query]]

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If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
08/16/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: [www.aetnadisability.com](http://www.aetnadisability.com)

[[EMAILSUBJECT: Response to your query]]**PLEASE DO NOT REPLY**

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If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
09/11/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager. She will contact Dr Totty to collect medical information if needed.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: [www.aetnadisability.com](http://www.aetnadisability.com)

[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

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If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
09/19/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: [www.aetnadisability.com](http://www.aetnadisability.com)

[[EMAILSUBJECT: Response to your query]]**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
09/30/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: [www.aetnadisability.com](http://www.aetnadisability.com)

[[EMAILSUBJECT: Response to your query]]**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
10/03/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>



PO Box 14560  
Lexington, KY 40512-4560  
800-354-1779

LEE

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**Facsimile Transmittal Sheet**

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To:		From:
Dr. Steven Nyquist		Aetna Disability
Employer:		Date:
Dell Inc		11/06/2014
Fax Number: 615-771-1109		CLAIM NUMBER:
		9452367
Phone number:		Sender's Phone Number:
		954-693-2227
		Sender's FAX Number:
		1-866-667-1987
Re: MR. ARTHUR DAVIS		Total No. of Pages Including Cover:5
Date of Birth: REDACTED		

☐ Urgent    ☐ For Review    ☐ Please Comment    ☐ Please Reply    ☐ Please Recycle

I am the Benefit Manager with Aetna handling Long Term Disability Benefits for the above patient. In order for us to continue Long Term Disability benefits, we need to obtain objective medical data to support the claim.

Please provide the following information:

Progress notes from 08/01/2014 to present with objective exam findings.

Please provide current treatment plan: \_\_\_\_\_

Last office visit \_\_\_\_\_ Next scheduled office visit \_\_\_\_\_

Return to work plan:

Does your patient currently have work capacity? Yes \_\_\_\_\_ No \_\_\_\_\_

Restrictions: \_\_\_\_\_

Anticipated Full Duty return to work date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE PROVIDE MEDICAL INFORMATION BY: ASAP

Your prompt response is necessary in order to avoid termination of your patient's claim.

Disclaimer:

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent

responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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The information contained in this document is CONFIDENTIAL. If you have received this in error, please fax immediately to 1-866-667-1987. Thank you.

Enclosed:  
Behavioral Health Clinician Statement



## Behavioral Health Clinician Statement

Aetna Life Insurance Company  
PO Box 14560  
Lexington, KY 40512-4560  
Fax: 1-866-667-1987

Patient Name	Provider Name	Clinical Manager Name
Patient Year of Birth	Provider Telephone Number	Clinical Manager Telephone Number
Patient Case Number Claim Number: 9452367	Provider Fax Number	Clinical Manager Fax Number

Patient Occupation: Inside Sales Account Mgmt Iii
--

Do you currently support your patient being out work? ☐ Yes ☐ No

### Diagnostic Impressions

Primary Diagnosis(es) Preventing Work (DSM V Code)	Mild	Moderate	Severe	Other Specifiers

Patient's Current Progress: ☐ Improved ☐ Stable ☐ Regressed

The patient has expressed the following barriers in returning to work:				
<input type="checkbox"/> Increase in work demand	<input type="checkbox"/> Conflicts with supervisor	<input type="checkbox"/> Anticipation of relapse	<input type="checkbox"/> Recent unfavorable work evaluation	
<input type="checkbox"/> Dissatisfaction with the job	<input type="checkbox"/> Medication complications	<input type="checkbox"/> Medical/Physical Complications	<input type="checkbox"/> Other: _____	

### Risk to Self/Others

1. Current suicidal ideation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please describe plan/intent:
2. Current homicidal ideation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please describe plan/intent:
3. Have you and the patient agreed upon measures to be taken should the threat to harm self/others become imminent?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please describe:
4. Is the patient able to report reasons for not harming self/others?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please describe:

### Emotional Functioning

1. Emotional state/mental status during exam (Describe affect, mood, range, lability, congruency with content).	
2. If the patient was tearful, was it appropriate to the content being discussed? <input type="checkbox"/> Yes <input type="checkbox"/> No, please explain:	
3. Requires assistance to compose self? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe:	
4. Panic attacks? <input type="checkbox"/> Yes <input type="checkbox"/> No	
a. Symptoms reported: _____	
b. Frequency of panic attacks/Duration of each attack: _____	
c. Intervention used: _____	
d. Panic attack ever observed in exam?: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe:	
Additional Examination Findings/Notes	



Patient Name	Provider Name	Clinical Manager Name
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**Cognitive Functioning**

1. Able to follow a three step command?	<input type="checkbox"/> Yes <input type="checkbox"/> No, please provide exam details:
2. Able to perform five operations of Serial 7's or 3's?	<input type="checkbox"/> Yes <input type="checkbox"/> No, please provide exam details:
3. Memory Functions:	<input type="checkbox"/> Digit span forward = _____ <input type="checkbox"/> Digit span backwards = _____ <input type="checkbox"/> 4 unrelated words after 5 minutes <input type="checkbox"/> Other measurement(s) _____
4. Applied focus and concentration in session for periods of:	<input type="checkbox"/> 30-50 min. <input type="checkbox"/> 15-30 min. <input type="checkbox"/> 5-10 min. <input type="checkbox"/> less than 5 min.
5. Expressed his/her current circumstances and responded to direct questions appropriately?	<input type="checkbox"/> Yes <input type="checkbox"/> No, please describe
6. Reasoning and/or Judgment:	<input type="checkbox"/> Within normal limits <input type="checkbox"/> Impaired, please describe:
7. Are psychotic symptoms present? (Delusions, hallucinations)	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe:
8. Was a mini mental status exam completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide score:
Additional Examination Findings/Notes	

**Behavioral Observations**

1. Behaviors observed during exam. Please provide specific details.	
2. Psychomotor activity:	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Impaired, please describe:
3. Presented with appropriate dress and hygiene in session?	<input type="checkbox"/> Yes <input type="checkbox"/> No, please describe:
4. Difficulty with impulse control?	<input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:
5. Speech:	<input type="checkbox"/> Normal <input type="checkbox"/> Slurred <input type="checkbox"/> Pressured <input type="checkbox"/> Stammering <input type="checkbox"/> Loud <input type="checkbox"/> Soft <input type="checkbox"/> Over Productive <input type="checkbox"/> Under Productive
Additional Examination Findings/Notes	

**Activities of Daily Living**

1. Is patient currently performing:		<input type="checkbox"/> Volunteer Work	<input type="checkbox"/> Attending School	<input type="checkbox"/> Self-Employed
		<input type="checkbox"/> Work at a Lesser Demanding Job	<input type="checkbox"/> No Work Activities in Any Capacity	
2. Significant weight/appetite changes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gain/loss within _____, (Time frame)		
3. Sleep disturbances?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please describe:		
4. Socialization problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please describe:		
5. Cleans/Maintains residence?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Performs routine shopping?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pays bills?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is patient able to safely operate an automobile or other motorized vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No, please describe:				
7. What does your patient do on a daily basis?				



Claim Number: 9452367

Patient Name	Provider Name	Clinical Manager Name
--------------	---------------	-----------------------

#### Treatment

	Start Date	End Date	Days Per Week	Frequency	Last Visit	Next Visit
<input type="checkbox"/> Inpatient Care						
<input type="checkbox"/> Partial Hospitalization Programs						
<input type="checkbox"/> Intensive Outpatient (IOP)						
<input type="checkbox"/> Outpatient Psychotherapy						
<input type="checkbox"/> Medication Management						

#### Medications

1. Please list all current medications.	
2. Any recent changes in medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe:
3. Medication side effects?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe:
Additional Examination Findings/Notes.	

#### Referrals

1. Have you referred your patient to any other providers?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide name and contact information:
2. Have you recommended that your patient stay home from work on disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Please specify the recommended Start Date ____ / ____ / ____ End Date ____ / ____ / ____	

#### Claimant Return To Work Status

1. Is your patient:	<input type="checkbox"/> Able to return to work FULL DUTY without modification. Full Duty release to return to work date: ____
2. If your patient is not returning to work to his/her occupation, what capacity does he/she have to work at a different occupation?	
3. What are the tasks related to your patient's occupation that he/she is able to perform at this time?	
4. Can your patient volunteer or work part time?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please indicate volunteer or part time with start date, number of hours per day, days per week, and duration of the limitations and restrictions. Please provide any other modifications for your patient to return to work.
5. Can your patient participate in vocational rehabilitation counseling?	
<input type="checkbox"/> Yes <input type="checkbox"/> No, please explain.	

**\*Please attach the most recent office notes\***

#### Signature/Exam Date

Signature	Date Exam Completed
Print Name	Date Form Completed
Credentials	

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.**

WKAB

GR-68317 (9-14) J

Page 1 of 1  
R-POD





PO Box 14560  
Lexington, KY 40512-4560  
800-354-1779

LEE

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**Facsimile Transmittal Sheet**

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To:		From:	
Dr. Tad Yoneyama		Aetna Disability	
Employer:		Date:	
Dell Inc		11/06/2014	
Fax Number: 615-916-3903		CLAIM NUMBER:	
		9452367	
Phone number:		Sender's Phone Number:	
		954-693-2227	
		Sender's FAX Number:	
		1-866-667-1987	
Re: MR. ARTHUR DAVIS		Total No. of Pages Including Cover:2	
Date of Birth: REDACTED			

☐ Urgent    ☐ For Review    ☐ Please Comment    ☐ Please Reply    ☐ Please Recycle

I am the Benefit Manager with Aetna handling Long Term Disability Benefits for the above patient. In order for us to continue Long Term Disability benefits, we need to obtain objective medical data to support the claim.

Please provide the following information:

Office visit notes from 09/01/2014 to present with Operative Report, Office visit notes, Procedure Notes (if applicable) and Objective exam findings and diagnostic test results (laboratory tests, x-rays, and MRI tests).

Please provide current treatment plan: \_\_\_\_\_

\_\_\_\_\_

Last office visit \_\_\_\_\_ Next scheduled office visit \_\_\_\_\_

Return to work plan:

Does your patient currently have work capacity? Yes \_\_\_\_\_ No \_\_\_\_\_

Restrictions: \_\_\_\_\_

\_\_\_\_\_

Anticipated Full Duty return to work date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE PROVIDE MEDICAL INFORMATION BY: ASAP

Your prompt response is necessary in order to avoid termination of your patient's claim.

Disclaimer:

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confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

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---

The information contained in this document is CONFIDENTIAL. If you have received this in error, please fax immediately to 1-866-667-1987. Thank you.

Enclosed:



PO Box 14560  
Lexington, KY 40512-4560  
SHAWNDR A LEE  
LTD BENEFIT MANAGER  
Phone: 800-354-1779  
Fax: 1-866-667-1987

11/24/2014

ARTHUR DAVIS  
**REDACTED**  
Franklin TN - 37068

Group Control No: 0476626  
Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

Dear ARTHUR C DAVIS:

The Dell Inc group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna).

We are writing in regards to your ongoing claim for Long Term Disability (LTD) benefits. Please review this entire letter as it contains important information regarding your eligibility for ongoing benefits.

We have made several attempts to reach your physician(s) Dr. Steven Nyquist and Dr. Tadayuki Yoneyama on 11/06/2014 and 11/21/2014 to obtain updated information on your claim. To date, we have not received the requested information.

In regard to disability, your policy indicates:

**A Period of Disability**

A period of disability starts on the first day you are disabled as a direct result of a significant change in your physical or mental condition occurring while you are insured under this Plan. You must be under the regular care of a physician. (You will not be deemed to be under the regular care of a physician more than 31 days before the date he or she has seen and treated you in person for the disease or injury that caused the disability.)

Your period of disability ends on the first to occur of:

- The date Aetna finds you are no longer disabled or the date you fail to furnish proof that you are disabled.
- The date you cease to be under the regular care of a physician.

If you continue to be disabled, your disability benefit plan requires you to be under the care of a physician and to submit continuing proof of your disability. Updated medical documentation to certify your disability will be needed from your disabling Physicians every 3 months or after every follow up appointment.

This information is necessary for us to determine whether you continue to meet the definition of disability described in your LTD plan, as it will provide us information regarding how your medical condition imposes limitations upon your ability to perform your work duties.

Provide us with current medical documentation which:

- Established that you are disabled from your own occupation;
- Includes medical documentation, such as chart notes and diagnostic test results, to support your diagnosis and

claim for disability; and

- Provides specific functional abilities, including any and all restrictions and limitations.

We encourage you to contact your providers and expedite this request, as it is ultimately your responsibility to provide proof of disability. Please forward this information to our office no later than 12/24/2014 or your LTD benefits may be jeopardized. If we do not receive the current office notes from all disabling physicians by 12/24/2014, your claim will be reviewed based on what is currently in your file and your claim may be closed.

If you have any questions, please call 800-354-1779.

Sincerely,

SHAWNDR A LEE  
LTD BENEFIT MANAGER  
Aetna Life Insurance Company



PO Box 14560  
Lexington, KY 40512-4560  
SHAWNDR LEE  
LTD BENEFIT MANAGER  
Phone: 800-354-1779  
Fax: 1-866-667-1987

12/09/2014

ARTHUR DAVIS

**REDACTED**

Franklin TN - 37068

Group Control No: 0476626  
Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

Dear ARTHUR C DAVIS:

The Dell Inc group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna).

We are writing in regards to your ongoing claim for Long Term Disability (LTD) benefits. Please review this entire letter as it contains important information regarding your eligibility for ongoing benefits.

On 11/24/2014, we advised you through mail that we have not been successful in obtaining updated medical information from your physician(s).

We have made several attempts to reach your physician(s) Dr. Steven Nyquist and Dr. Tadayuki Yoneyama on 11/06/2014 and 11/21/2014 to obtain updated information on your claim. To date, we have not received the requested information.

In regard to disability, your policy indicates:

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We encourage you to contact your providers and expedite this request, as it is ultimately your responsibility to provide proof of disability. Please forward this information to our office no later than 12/24/2014 or your LTD benefits may be jeopardized. If we do not receive the current office notes from all disabling physicians by 12/24/2014, your claim will be reviewed based on what is currently in your file and your claim may be closed.

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Sincerely,

SHAWNDR A LEE  
LTD BENEFIT MANAGER  
Aetna Life Insurance Company



[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
12/05/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager along with a request to call you.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>

[[EMAILSUBJECT: Response to your query]]

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Dell Inc  
12/19/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager. Once that information is received your Claim Manager will review the information and send you a confirmation letter with the details about your claim, once the review has been completed.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>



PO Box 14560  
Lexington, KY 40512-4560  
800-354-1779

LEE

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**Facsimile Transmittal Sheet**

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To:		From:	
Dr. Tad Yoneyama Heritage Medical		Aetna Disability	
Employer:		Date:	
Dell Inc		12/23/2014	
Fax Number: 615-916-3903		CLAIM NUMBER:	
		9452367	
Phone number:		Sender's Phone Number:	
		800-354-1779	
		Sender's FAX Number:	
		1-866-667-1987	
Re: MR. ARTHUR DAVIS		Total No. of Pages Including Cover:	
Date of Birth: REDACTED			
		1	

☐ Urgent    ☐ For Review    ☐ Please Comment    ☐ Please Reply    ☐ Please Recycle

I am the Benefit Manager with Aetna handling Long Term Disability Benefits for the above patient. In order for us to continue Long Term Disability benefits, we need to obtain objective medical data to support the claim.

Please provide the following information:

Office visit notes from 09/01/2014 to present with Operative Report, Office visit notes, Procedure Notes (if applicable) and Objective exam findings and diagnostic test results (laboratory tests, x-rays, and MRI tests).

Please provide current treatment plan: \_\_\_\_\_

\_\_\_\_\_

Last office visit \_\_\_\_\_ Next scheduled office visit \_\_\_\_\_

Return to work plan:

Does your patient currently have work capacity? Yes \_\_\_\_\_ No \_\_\_\_\_

Restrictions: \_\_\_\_\_

\_\_\_\_\_

Anticipated Full Duty return to work date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE PROVIDE MEDICAL INFORMATION BY: ASAP

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Do you need documentation that your patient has authorized you to release information to us? We have forms for that available on our online portal. Either you or your patient can go to [www.aetnadisability.com](http://www.aetnadisability.com) to download an authorization form and print it out.

**Disclaimer:**

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Enclosed:

[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
12/23/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>

[[EMAILSUBJECT: Response to your query]]**PLEASE DO NOT REPLY**

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If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
12/29/2014

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Cobra is the continuation of your medical or dental benefits. Long Term Disability benefits are not affected by COBRA.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>

[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
01/07/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>



PO Box 14560  
Lexington, KY 40512-4560  
SHAWNDR A LEE  
LTD BENEFIT MANAGER  
Phone: 800-354-1779  
Fax: 1-866-667-1987

January 12, 2015

ARTHUR DAVIS  
**REDACTED**  
Franklin TN - 37068

Dear Arthur C Davis:

**We've made a decision on your claim**

We have recently completed a review of your claim under Dell Inc. Long Term Disability (LTD) benefits plan and have terminated benefits effective 01/12/2015 for the reason(s) explained below.

**Test of Disability**

From the date that you first became disabled and until monthly benefits are payable for 24 months you meet the test of disability on any day that:

- \* You cannot perform the material duties of your own occupation solely because of an illness, injury or disabling pregnancy-related condition; and
- \* Your earnings are 80% or less of your adjusted pre disability earnings.

After the first 24 months of your disability that monthly benefits are payable, you meet the plan's test of disability on any day you are unable to work at any reasonable occupation solely because of an illness, injury or disabling pregnancy-related condition.

**When Long Term Disability Benefit Eligibility Ends**

You will no longer be considered as disabled nor eligible for long term monthly benefits when the first of the following occurs:

- The date you no longer meet the LTD test of disability, as determined by Aetna.
- The date you are no longer under the regular care of a physician.
- The date you fail to provide proof that you meet the LTD test of disability.

Our review consisted of the following pertinent documents contained in your claim file;

MRI report dated 11/06/2014  
Office visit notes from Paul Buechel dated 10/16/2014 and 12/02/2014

On 12/23/2014 Dr. Buechel submitted office visit notes dated 10/16/2014 advising that you were referred by your Primary Care Physician and seen for subject complaints of low back pain. However, there were no objective findings to support impairment. On Office notes dated 12/02/2014, Dr. Buechel advised that you were seen for a follow up to your low back pain with subjective complaints of symptoms worsens and nothing relieves the symptoms. The objective findings were insufficient to support impairment.

MRI of the lumbar spine completed on 11/06/2014 reflects the following: The 5 lumbar type vertebral segments



are assumed for purpose of this diction with the conus terminating at L1. There is no lumbar malalignment. Mild degenerative marrow signal abnormality is appreciated. Review of the visualized retroperitoneal structures is unremarkable.

You were notified in writing and telephonically on 11/24/2014, 12/09/2014, and 12/23/2014, advising you that current medical data was needed which supports a funational impairment that prevents you from performing the core functions of your own occupation.

Based on the review of the medical documentation on file, it has been determined there are insufficient examination findings or diagnostic testing documented to support a level of functional impairment that would preclude you from performing the sedentary physical demand duties of an INSIDE SALES ACCOUNT MGMT III as defined by your plan. Consequently, your Long Term Disability benefits are being terminated effective 01/12/2015.

Under sepearte cover, you will receive your final payment for the period of 01/01/2015 through 01/11/2015 in the amount of \$1,162.56.

In making our claim decision, we do not waive any rights or defenses available to us under the plan. We will review any additional information you care to submit, such as medical information from all physicians who have treated you for the condition(s), including but not limited to:

- a detailed narrative report for the period 01/12/2015 through present date outlining the specific physical and/or mental limitations related to your condition that your doctor has placed on you as far as gainful activity is concerned; physician's prognosis, including course of treatment, frequency of visits, and specific medications prescribed;
- diagnostic studies conducted during the above period, such as test results, X-rays, laboratory data, and clinical findings;
- any information specific to the condition(s) related to your disability claim that would assist with the evaluation of your disability status; and
- any other information or documentation that would assist us with the review of your claim.

**If I don't agree, what can I do next?**

If this disability claim has been denied in whole or in part, you can ask us to look at it again. This is called an Appeal.

- You have 180 days from the date on this letter to ask us to review your claim by sending a written request. If you wait longer than that, you'll lose your right to have us review your claim. That means you'll lose your right to challenge our decision in court or anywhere else.
- To ask for a disability claim review, fax us a letter at **1-855-733-1262** or send it to this address:

Aetna Life Insurance Company  
Dell Inc Appeals  
PO Box 14578  
Lexington, KY 40512-4578

Make sure your request includes:

- Your name and employee ID number (if you have one)
- The name of your employer
- Your disability claim number (**9452367**)
- Any information you didn't already send us. This could mean medical records, test results or anything else that shows why you weren't able to do your job.

If you'd like copies of the documents we already have, you can ask for that in your request.

In most cases, you'll have our appeal decision within 45 days from when we get your request. If we're not able to make an appeal decision within 45 days, we'll send you an update to tell you why.

If you don't agree with our appeal decision, you can file a law suit under section 502(a) of a law called ERISA. You would have to do that within one year from the date of our final decision. If you wait longer than a year, you'll lose your right to file a law suit based on this claim.

**We're here to help you**

For questions about this letter or your claim, you can call us at **800-354-1779**. You can also visit us at **<https://www.aetnadisability.com>**.

Sincerely,

SHAWNDRA LEE  
LTD BENEFIT MANAGER  
Aetna Life Insurance Company

[[EMAILSUBJECT: DAVIS, A. - LTD Claim ID: 9452367]]

Client Name: Dell Inc  
EE Name: MR. ARTHUR DAVIS  
Work State: Tennessee  
Pref Cont #: **REDACTED**  
Claim Nbr: 9452367

Date of Hire: 05/22/2006

LTD Plan Name: DD

Claim Status: Terminated

First Day Absent: 10/09/2013  
Last Day Worked: 10/08/2013  
Disability Date: 10/9/2013  
Benefit Begin Date: 4/7/2014  
Benefit End Date: 10/31/2028  
Approved Through: 01/11/2015  
Total # Days Authorized: 731  
Max Benefit End Date: 10/31/2028 Status: Terminated  
Reason: Disability Not Supported  
Return to work Information:  
Work Status: Not At Work  
Description:

From Date: 01/12/2015

Claim Owner: SHAWNDR LEE  
Phone: 800-354-1779, extension 6932227 Fax: 1-866-667-1987



PO Box 14578  
Lexington, KY 40512-4578  
CANDICE HOY  
Appeal Assistant  
Phone: 800-354-1779  
Fax: 1-855-733-1262

January 29, 2015

ARTHUR DAVIS  
**REDACTED**  
Franklin TN 37068

Dear Arthur Davis:

**Good news - your request is in process**

We received your appeal request for your Long-Term Disability (LTD) claim (**claim # 9452367**) on January 22, 2015. We attached two forms for you to complete to help us obtain some additional information. If you don't complete them, we'll still process your appeal. When your case is assigned to an Appeal Specialist, that person may be contacting you to obtain additional information on your appeal.

**Let's work together**

If you plan to send more information to support your appeal:

- Call us as soon as possible to let us know, and;
- Send us the information, so we can consider it during our review

Please mail or fax the additional information to:

Aetna Life Insurance Company  
PO Box 14578  
Lexington, KY 40512-4578  
Fax: **1-855-733-1262**

**We're here to help you**

It's important that you keep a copy of this letter for your records. For questions about this letter or your appeal, you can call us at **800-354-1779**.

Sincerely,

Candice Hoy  
Appeal Assistant  
Aetna Life Insurance Company

Enclosures:

Authorization to Request Protected Health Information  
Disability Appeal Request Form

Claim Number: 9452367



## Authorization For Aetna To Request Protected Health Information Necessary To Process A Disability Claim

Please Read The Following Carefully Before Completing Your Authorization. You May Refuse To Sign This Authorization. (See Section 6.)

**1. Member Information (Information About Person For Whom This Authorization Is Requested.)**

Last Name DAVIS		First Name ARTHUR		Middle Initial
Claim Number		Year of Birth	Daytime Telephone Number (include area code)	
Street Address		City, State and ZIP		

**2. This form requests a Member's unconditioned authorization for Aetna to ask another person or organization to disclose Member's Protected Health Information ("PHI") to Aetna for the purpose of processing my disability claim.**

**3. The specific PHI we are asking you to authorize Aetna to request is (This section completed by Aetna.)**

*Any and all medical information including but not limited to information which relates to psychiatric or mental health, drug, substance abuse, and/or HIV Infection, including AIDS and related illnesses, concerning health care, advice and treatment and prescription history records(including but not limited to, medical records, histories, physical or diagnostic examinations reports and treatment notes).*

**4. If you prefer to authorize the request of only selected categories of information, please indicate below which types of information may be disclosed. (This section completed by Member)**

<input type="checkbox"/> Health (This includes medical, dental, pharmacy, vision, and flexible spending account information)
<input type="checkbox"/> Behavioral Health (e.g., mental health, drug and alcohol abuse treatment)
<input type="checkbox"/> Disability <input type="checkbox"/> Life Insurance <input type="checkbox"/> Long Term Care <input type="checkbox"/> Workers' Compensation
<input type="checkbox"/> Other: (please specify) _____

**5. By signing this form, you will authorize Aetna to request PHI described above from the following persons or organizations (or classes of persons or organizations.)**

*Service Providers, including but not limited, to physicians, therapists, medical practitioners, health care professionals, workers' compensation professionals, diagnostic facilities, hospitals, clinics and pharmacy related service organizations (including individuals or facilities which provide rehabilitation services or treatment).*

**6. Expiration of this Authorization**

This authorization is valid throughout the processing and any term of your disability claim unless you indicate a shorter period below.	
_____	through _____
mm/dd/yyyy	mm/dd/yyyy

Please review and complete important information on the reverse of this form.

WKAB  
GR-67940-26 (8-13) D

Page 1 of 3  
R-POD



Claim Number: 9452367

<b>Employee Name</b> ARTHUR DAVIS
--------------------------------------

**7. Important: Your signature below means that you understand and agree to the following:**

- You authorize Aetna to request from the persons or organizations named above, the PHI described above, for the purposes stated above.
- The information to be disclosed may be protected by law. Information disclosed under this authorization may be re-disclosed and no longer protected by federal privacy regulations.
- Failure to complete this form may prevent Aetna from receiving information necessary for the processing of your disability claim, which may result in a disability claim denial. Failure to complete this form will not however impact your receipt of medical services from providers.
- You may revoke this Authorization at any time by notifying Aetna in writing, but please note that actions Aetna has taken before we received your revocation will still be valid under this authorization.
- You may receive a copy of this form if you request it in writing from the address listed below.

**8. Signature of Member or Legal Representative**

Signature of Member or Legal Representative	Date
Print Name	

**If not the Member,** describe your relationship to the Member:

- ☐ Caregiver  
☐ Legal Representative  
☐ Other: \_\_\_\_\_

If Member's legal representative is signing this Authorization, you must furnish a copy of the health care power of attorney, or other relevant document designating you as the representative.

**NOTICE TO RECIPIENT(S) OF INFORMATION (Section 2. above):**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. ***Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.***

**Return this completed form to:** **Aetna Life Insurance Company**  
PO Box 14560  
Lexington, KY 40512-4560

**Telephone Number:** 800-354-1779  
**Fax Number:** 1-866-667-1987

**WKAB**  
GR-67940-26 (8-13) D

Page 2 of 3



Claim Number: 9452367

Employee Name DAVIS, ARTHUR
--------------------------------

#### 9. Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

WKAB  
GR-67940-26 (8-13)

Page 3 of 3





## Disability Appeal Request Form

We ask that you submit a request for appeal in writing. You may complete this form to assist us in review of your disability claim. You may also attach additional pages if you need more room to answer the questions below.

*Note: Completion of this form is voluntary. You may use this form to submit your appeal. If you have already submitted your appeal you may use this form to supplement your appeal, along with any other information you would like us to review with your appeal.*

Under ERISA guidelines, if you disagree with your claim determination, in whole or in part, you may file a request to appeal this decision within 180 days of receipt of this notice. The review of appeal will consist of a review of your claim based on information already existing in your file along with any additional information, records, documents, comments or other relevant material you submit in support of your appeal.

Mail or fax this completed form along with a signed copy of the enclosed Authorization for Aetna to Request Protected Health Information Necessary to Process a Disability Claim and any additional documentation to:

**Aetna Disability Appeals**

PO Box 14578

Lexington, KY 40512-4578

Phone: **1-800-688-6820**

Fax: **1-855-733-1262**

Claimant Name:	Claimant Employer:	Claim Number: 9452367
Current Mailing Address:	Can we contact you via email? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Claimant Email Address:	
Home Phone:	Cell Phone:	
Preferred Method of Contact: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Email		
May we leave you a detailed voicemail message? (Please note that the message may include claim and/or medical information) Yes <input type="checkbox"/> No <input type="checkbox"/>		

**If someone other than you is filing this appeal, please provide the following:**

Name of person assisting:	Daytime phone number:
Relationship to member:	Evening phone number:

**Please answer the following questions as applicable:**

**(Note: any additional information supplied will be utilized in support of your appeal review):**

Please state the reason why you are appealing the claim denial.





Claimant Name:	Claimant Employer:	Claim number: 9452367
----------------	--------------------	--------------------------

**Please answer the following questions as applicable:**

For what time period are you appealing for benefits?	From:	To:
Have you returned to work? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If not, do you have a projected return to work date?		
What is your job title?		
Please list the requirements of your job?		
Please explain the condition(s) that are preventing you from returning to work.		
What specific aspects of your job are you unable to perform and why?		
Who are your treating providers and when did you last see each provider? If you are still receiving treatment, when is your next appointment(s)?		
Provider Name:	Date last seen:	Date next appointment:
Are there additional records available which you intend to submit for appeal review? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, please submit all available information along with this completed appeal form.		

\_\_\_\_\_  
Claimant signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of authorized representative

\_\_\_\_\_  
Date



[[EMAILSUBJECT:Appeal Receipt Notification]]

01/29/2015

Group Control No: 0476626  
Employer: Dell Inc.  
Employee: ARTHUR C. DAVIS  
Disability Claim No: 9452367

This note is to advise that Aetna has received an appeal for your Employee ARTHUR C DAVIS in regards to the LTD adverse claim determination. You will be notified of the appeal determination by March 8, 2015. If it is determined that additional time is needed to complete the appeal review, or if your Employee needs more time to submit additional information, we will send you notification that the time frame has been extended.

Should you have any questions, feel free to contact our office at 800-354-1779.

Sincerely,

Candice Hoy  
Appeal Assistant  
Aetna Life Insurance Company

[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
02/20/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

We received the Authorization to Request Protected Health Information, the Disability Appeal Request Form and your medical records for review on 02/09/2015. We will send you a confirmation letter with the details about your claim, once the review has been completed.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>

[[EMAILSUBJECT: Response to your query]]**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
02/25/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>

[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
02/25/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>

[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
03/04/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

We are able to list one healthcare provider as 'Active' in our system. Typically, the provider listed as 'Active' either primarily handles your disability or is the provider we have most recently contacted for medical records. Any additional provider names and contact information provided to us are kept on file and accessed when needed.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>



PO Box 14578  
Lexington, KY 40512-4578  
CHARLAI LANG  
SENIOR LTD BENEFIT MANAGER  
Phone: 800-354-1779  
Fax: 1-855-733-1262

March 4, 2015

ARTHUR DAVIS  
**REDACTED**  
Franklin TN - 37068

Dear Arthur C Davis:

**Your request is in process**

We're reviewing your appeal that was received on January 22, 2015 for your Long-Term Disability (LTD) claim (**claim # 9452367**), but we need more time because your file was sent for a specialty matched medical opinion, and we are currently awaiting the report from that peer review.

Given this reason we'll need a forty-five (45) day extension to complete the appeal review. We hope to be able to make a decision before April 22, 2015, but we'll try to complete the review prior to that date.

**We're here to help you**

It's important that you keep a copy of this letter for your records. For questions about this letter or your claim, you can call me at **800-354-1779**.

Sincerely,

CHARLAI LANG  
SENIOR LTD BENEFIT MANAGER  
Aetna Life Insurance Company

[[EMAILSUBJECT: Notice of LTD Benefit Appeal Extension]]

Date: 03/04/2015

From: Aetna Disability Appeals Unit

Employee: ARTHUR DAVIS

RE: Dell Inc LTD Benefit

Employee Id Number: 900600

Claim Number: 9452367

We are in the process of reviewing information related to the appeal request for ARTHUR DAVIS, which was received on January 22, 2015.

This letter is to notify you that a forty-five (45) day extension of time for the review of ARTHUR DAVIS appeal has been taken. We expect to render a decision by April 22, 2015.

Once a determination has been rendered, you will be notified in writing.

Should you have questions or need additional information regarding this matter, please feel free to contact me at 1-800-688-6820, extension 9346.

Sincerely,

CHARLAI LANG  
SENIOR LTD BENEFIT MANAGER  
Aetna Life Insurance Company



[[EMAILSUBJECT: Response to your query]]**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
03/11/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>

[[EMAILSUBJECT: Response to your query]]**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
03/11/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>

[[EMAILSUBJECT: Response to your query]]**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
03/18/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>

[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
03/21/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your request for a copy of your disability file has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>

[[EMAILSUBJECT: Response to your query]]**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
04/13/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your request for a copy of your claim file was forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>

[[EMAILSUBJECT: Notice of LTD Benefit Appeal Determination]]

Date: 04/24/2015

From: Aetna Appeals Unit

Employee: MR. ARTHUR DAVIS

RE: Dell Inc LTD Benefit

Date Appeal Determination Letter Sent: April 24, 2015

Employee ID: 900600

Claim Number: 9452367

We have completed our review of the appeal of the termination of LTD benefits for the above named employee. Based upon our review, the initial decision has been upheld effective 1/12/2015.

.

Written notification of this determination has been sent to the employee.

According to the LTD group policy under which your employee is covered, this review is final and not subject to further review.

If you have questions regarding this determination, please contact me at 1-800-688-6820 .

Sincerely,

CHARLAI LANG

Disability Appeals Specialist



PO Box 14578  
Lexington, KY 40512-4578

Phone: 800-354-1779  
Fax: 1-855-733-1262

April 24, 2015

ARTHUR DAVIS  
**REDACTED**  
Franklin TN - 37068

Dear Arthur C Davis:

**We've made a decision on your appeal**

We finished reviewing your appeal for the Long-Term Disability claim (**claim # 9452367**). We agreed with the original decision to terminate your benefit as of January 12, 2015.

**The reason for our decision**

The information you and your doctor sent shows:

You went out of work effective October 9, 2013 due to a right and left rotator cuff tears and bicep tendon attrition following a motor vehicle accident dated September 27, 2013. You had a surgical on October 11, 2013, January 31, 2014 and February 28, 2014. These surgeries consisted of an open rotator cuff repair including a decompression and bicep tenodesis of the left arm, a repair of a massive right rotator cuff tendon rupture and a right rotator cuff repair with excision of the distal clavicle, subacromial bursa debridement and subacromial decompression. You also had a partial medial and lateral meniscectomy of the left knee on April 14, 2014.

Postoperatively, Dr. Renfro reported on your follow up exam dated April 25, 2014 you had slight swelling in the knee and you were in therapy for your shoulders and doing well. You needed more strengthening to your shoulders. On November 6, 2013 you had a MRI of your lower back due to ongoing complaints of pain. It revealed multilevel disk bulges and no spinal stenosis. There was multilevel facet joint ligamentum flavum hypertrophy with mild right neuroforaminal narrowing at L4-L5 and mild left neuroforaminal narrowing at L5-S1 and mild degenerative is disease at L3-L4.

On December 19, 2013 you had a follow up visit with Dr. Kauffman. You reported that your back pain began on September 27, 2013. You described your symptoms as being sharp shooting pains which radiated into the right lower part the posterior region. You also advised that the pain intensified at night time. Your reported you had tried physical therapy, nonsteroidal anti-inflammatory pain medication and bedrest. You reported the physical therapy was only partially effective in relieving your pain. On examination Dr. Kauffman opined mild reduced range of motion in the lumbar spine, normal strength, normal muscle tone, straight leg raise was negative bilaterally, normal sensation in the lower extremities, normal pulse and reflexes. It was recommended you try physical therapy and gabapentin.

On January 16, 2014 Dr. Cote advised you reported therapy and pain medications are not working for his chronic back pain. On exam there were no neurologic deficits, your range of motion extension was limited to 50 percent , flexion 75 percent and side bending to the right 75 percent which was aggravated by discomfort. You had severe pain to palpation over the gluteus maximus, piriformis, quadratus lumborum on the right and left side. You attended physical therapy for a period of time and your range of motion was at a 100 percent by February 7, 2014. You continued to complain of difficulty with sitting for prolonged periods of time and continued pain. Due to your chief complaint of burning sensations, tingling in your legs along with neck pain and EMG was performed on June 13, 2014. It revealed you had no weakness or numbness. Dr. Buechel indicated at your office visit dated October 16, 2014 you reported your symptoms were better with medication however aggravated by exertion and movement in general.

You had a repeat MRI on November 6, 2014 which revealed scattered lumbar degenerative and stenotic findings. There were mild stenosis and a incomplete evaluation of the reported degenerative changes at the T10-11 level. You reported not sleeping, not being able to sit longer than 15 minutes. You were taken a prescription of doxepin for which gave you sided of effects of not being able to walk up for excessive periods. On exam you had red cued sensation on the right L4 and S1 dermatomes. You had tenderness over the L4 to SI and Dr. Buechel opined that you could not sit for a 10 hour work shift. Your medications were increased and you were referred to pain management.

We also had an independent doctor who specializes in Orthopedic Surgery review the information. We've written a summary of the doctor's review below.

The peer reviewer opined that you have chronic low back pain. Most of the clinical examinations revealed a normal sensory motor examination outside of Dr. Cote noting decreased sensation at the L4 and S1 level, Dr. Yoneyama and Dr. Green suggested you remain off work due to your subjective complaint of back and leg pain. However there were no objective findings to correlate with chief complaint of pain. The peer reviewer also completed consults with Dr. Buechel, Dr. Green and Dr. Renfro and Dr. Yoneyama.

Dr. Buechel opined there was difficulty gaining control of your back pain however there was never any dramatic objective findings to correlate with your subjective complaint. Dr. Renfro opined you currently have a recurrent tear in the left rotator cuff tendon. An MRI revealed fatty infiltration in the supraspinatus and infraspinatus muscles which is now irreparable. You were sent for a second opinion to determine if surgical intervention is an option. Dr. Renfro also advised you had the ability to work a sedentary occupation with restrictions of no lifting more than 5 pounds and no reaching at or above shoulder height. Dr. Yoneyama opined you have severe back pain. Dr. Yoneyama felt it was neuropathic pain and that you should not work.

Based on the medical information and the telephonic consults with your physicians. There were no supportive information preventing you from maintaining a sedentary work capacity. You showed a high level of physical capabilities when you travelled to multiple treatment visits, exercise programs and even enrolled in a spinning class which indicates a higher level then sedentary activity.

Your Dell Inc LTD group policy says:

#### **Test of Disability**

From the date that you became disabled and until monthly benefits are payable for 24 months you meet the test of disability on any day that:

- You cannot perform the material duties of your own occupation solely because of an illness, injury or disabling pregnancy-related condition; and
- Your earnings are 80% or less of your adjusted predisability earnings.

After the first 24 months of your disability that monthly benefits are payable, you meet thee plan's test of disability on any day you are unable to work at any reasonable occupation solely because of an illness, injury or disabling pregnancy-related condition.

#### **Important Note**

The loss of a professional or occupational license or certification that is required by your own occupation does not mean you meet the test of disability. You must meet the plan's test of disability to be considered disabled.

#### **If I don't agree, what can I do next?**

To ask for a copy of all the documents we have, fax us a letter to **1-855-733-1262** or send it to this address:

Aetna Life Insurance Company  
Dell Inc Appeals  
PO Box 14578  
Lexington, KY 40512-4578

Make sure your request includes:

- Your name and employee ID number (if you have one)
- The name of your employer



- Your claim number (**9452367**)

Since we've made our final decision, no other action will be taken by us.

If you don't agree with our appeal decision, you can file a lawsuit under section 502(a) of a law called ERISA. If you wait too long, you may lose your right to file a lawsuit based on this claim. Make sure to check your plan brochure or summary plan description to see if it gives you the time frame to file a lawsuit.

It's important that you keep a copy of this letter for your records. For questions about this letter or your claim, you can call me at **800-354-1779**.

Sincerely,

Charlai Lang  
Disability Appeals Specialist  
Aetna Life Insurance Company

[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
04/18/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Appeal Specialist.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>

[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
04/20/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your e-mail has been forwarded to your Claim Manager.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>

[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
04/23/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

Your update has been forwarded to your Claim Manager along with a request to call you.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>



**PO Box 14560**  
**Lexington, KY 40512-4560**

Phone: 800-354-1779  
Fax: 1-866-667-1987

April 24, 2015

ARTHUR DAVIS  
**REDACTED**  
Franklin TN - 37068

Group Control No: 0476626  
Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

Dear Arthur C Davis:

The Dell Inc Long-Term Disability (LTD) group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna).

We are writing to you regarding your Long-Term Disability (LTD) benefits provided by your employer, Dell Inc, under the above referenced plan.

Per your request, attached is a copy of your file.

If you have any questions, please call 800-354-1779.

Sincerely,

CHARLAI LANG  
Disability Appeals Specialist  
Aetna Life Insurance Company

[[EMAILSUBJECT: Response to your query]]

**PLEASE DO NOT REPLY**

***This mailbox is not monitored on a daily basis.***

If you have any questions regarding this communication, please contact Aetna at 800-354-1779.

Dell Inc  
05/07/2015

Dear MR. ARTHUR DAVIS,

Thank you for using the secure member website to contact Aetna Disability. This is in response to your email concerning Claim #: 9452367.

We received a letter of representation and appeal request from Cody Allison and Associates on 04/28/2015. This information was forwarded to your Appeal Specialist for review.

Please let us know if we can provide additional assistance.

Thank you,  
Aetna Disability and Absence Management Services  
Aetna Fax #: 1-866-667-1987  
Visit us on the Web: <https://www.aetnadisability.com>



**PO Box 14560**  
**Lexington, KY 40512-4560**

Phone: 800-354-1779  
Fax: 1-866-667-1987

May 28, 2015

K Cody Allison  
501 Union Street Suite 502  
Nashville, TN 37219

Group Control No: 0476626  
Employer: Dell Inc  
Employee: MR. ARTHUR DAVIS  
Disability Claim Case No: 9452367

Dear Arthur C Davis:

The Dell Inc Long-Term Disability (LTD) group policy (Policy) is underwritten by Aetna Life Insurance Company (Aetna).

We are writing to you regarding your client's Long-Term Disability (LTD) benefits provided by your employer, Dell Inc, under the above referenced plan.

Per your request attached is a copy of your client's claim file and policy.

If you have any questions, please call 800-354-1779.

Sincerely,

CHARLAI LANG  
Disability Appeals Specialist  
Aetna Life Insurance Company

#### YOUR GROUP POLICY

This is your Group Policy. We feel certain that you will be pleased with this new format.

Your Group Policy consists of:

- a policy “shell” containing general provisions relating to policyholder/insurance company matters, and
- a certificate (including the Schedule of Benefits) containing the complete plan of benefits.

As changes in the plan occur, new or replacement pages will be issued and, when necessary a new or replacement certificate, Schedule of Benefits (SOB) or amendment which will be attached to a cover rider to the policy.



# Aetna Life Insurance Company



## **Summary Concerning Coverage, Limitations, and Exclusions under the Alaska Life and Health Insurance Guaranty Association Act**

A resident of Alaska who purchases life insurance, annuities, or accident and health insurance should know that an insurance company licensed in this state to write these types of insurance is a member of the Alaska Life and Health Insurance Guaranty Association. The purpose of this association is to assure that a policyholder will be protected within statutory limits if a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the guaranty association is not unlimited. This protection is not a substitute for your care in selecting a company that is well managed and financially stable.

### **Important Disclaimer**

**The Alaska Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Alaska. You should not rely on coverage by the Alaska Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.**

**Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk.**

**Your insurance company or its agent is required by law to give or send you this notice. However, your insurance company and its agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.**

The state law that provides for this safety net coverage is called the Alaska Life and Health Insurance Guaranty Association Act. The full text of the act can be found in AS 21.79.010 –21.79.990. Provided below is a brief summary of this law's coverages, exclusions, and limits. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations under the act or the rights or obligations of the guaranty association.

### **Coverage**

Generally, an individual will be protected by the life and health insurance guaranty association if the individual lives in Alaska and holds a life or health insurance contract or annuity contract, or if the insured is insured under a group insurance contract issued by a member insurer. The beneficiary, payee, or assignee of an insured person is protected as well, even if a non-resident of Alaska.

### **Exclusions from Coverage**

The association does not protect a person holding a policy if

- the individual is eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization that is not a member of the Alaska Life and Health Insurance Guaranty Association.

The association does not provide coverage for

- a policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus; a policy of reinsurance (unless an assumption certificate was issued);
- an interest rate yield that exceeds an average rate;
- a dividend;
- a credit given in connection with the administration of a policy by a group contract holder;
- an employer's plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer;
- certain obligations to provide a book value accounting guaranty for defined contribution benefit plan participants;
- that part of a policy or contract that provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract.

#### **Limits on Amount of Coverage**

The act also limits the amount the association is obligated to pay. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were issued by the same company, even if such contracts provided different types of coverages, the association will pay a maximum of

- \$300,000 in net life insurance death benefits and no more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance;
- for health insurance benefits, \$100,000 for coverages not defined as disability, basic hospital, medical, and surgical, or major medical insurance, including any net cash surrender and net cash withdrawal values;
- \$300,000 for disability insurance;
- \$500,000 for basic hospital, medical, and surgical or major medical insurance;
- \$100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal value;
- with respect to a structured settlement annuity, \$100,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;
- \$100,000, in the aggregate, of present-value annuity benefits, including net cash surrender and net cash withdrawal values with respect to an individual participating in a governmental retirement plan established under 26 U.S.C. 401, 26 U.S.C. 403(b), or 26 U.S.C. 457 and covered by an unallocated annuity contract, or to a beneficiary of the individual if the individual is deceased;
- \$5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts held by that contract holder, with respect to any one contract holder or plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts.

*Note to benefit plan trustees or other holders of unallocated annuities (GICs, DA Cs, etc.) covered by the act:* for unallocated annuities that fund governmental retirement plans under sections 401 (k), 403(b), or 457 of the Internal Revenue Code, the limit is \$100,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than \$300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of \$5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases the contract limits also apply.

**Complaints and Company Financial Information**

A written complaint to allege violation of any provision of the Alaska Life and Health Insurance Guaranty Association Act must be filed with the Division of Insurance, 550 West Seventh Avenue, Suite 1560, Anchorage, Alaska, 99501-3567; telephone (907) 269-7900. Financial information for an insurance company, if the insurance information is not proprietary, is available at the same address and telephone number. The guarantee association should not be contacted regarding the financial information of an insurance company.

This information is provided by:

Alaska Life and Health Insurance Guaranty Association  
1007 West Third Avenue  
Anchorage, Alaska 99501  
(907) 243-2311

Division of Insurance  
550 West Seventh Avenue, Suite 1560  
Anchorage, Alaska, 99501-3567  
(907) 269-7900

# Aetna Life Insurance Company



## **Limitations and Exclusions under the Arkansas Life and Health Insurance Guaranty Association Act**

Residents of this state who purchase life insurance, annuities, or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

### **Disclaimer**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in the state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association  
C/O The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

### **Coverage**

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity, or health insurance contract or policy, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

## Exclusions from Coverage

However, persons owning such policies are NOT protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the individual has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them); unallocated annuity contracts (which give rights to group contractholders, not individuals); unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

## Limits on Amount of Coverage

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$ 300,000--no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$ 300,000 limit, the Association will not pay more than \$ 300,000 in health insurance benefits, \$ 300,000 in present value of annuity benefits, or \$ 300,000 in life insurance death benefits or net cash surrender values--again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$ 1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

# NOTICE TO EMPLOYERS

## **Important Information to Employees**

The Arkansas Insurance Department requires that employees located in Arkansas be furnished with a notice advising them who to contact in the event of a question about group insurance. The form that follows entitled "Important Information" is provided to you in compliance with the requirement.

All employees located in Arkansas who are or become covered by your group plan insured by Aetna, should be provided a copy of the form. The form can be distributed in the manner you deem most appropriate.

## **Important Information**

In the event you need to contact someone about your insurance coverage, you may contact Aetna Life Insurance Company at the following address and telephone number:

Aetna Life Insurance Company  
151 Farmington Avenue  
Hartford, CT 06156  
(860) 273-0123

If you have been unable to contact or obtain satisfaction from Aetna, you may contact the Arkansas Insurance Department at:

Arkansas Insurance Department  
Consumer Services Division  
400 University Tower Building  
1123 South University Avenue  
Little Rock, AR 72204  
(501) 686-2945

# Aetna Life Insurance Company



## California Life And Health Insurance Guaranty Association Act Summary Document And Disclaimer

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the California Life and Health Insurance Guaranty Association ("CLHIGA"). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Association is not unlimited, as noted in the box below, and is not a substitute for consumers' care in selecting insurers.

### Disclaimer

The California Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.**

Policyholders with additional questions should first contact their insurer or agent or may then contact:

California Life and Health Insurance Guaranty Association  
P.O. Box 16860  
Beverly Hills, CA 90209 or

Consumer Service Division  
California Department of Insurance  
300 South Spring Street  
Los Angeles, CA 90013

Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

### Coverage

Generally, individuals will be protected by the California Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

### **Exclusions from Coverage**

However, persons holding such policies are not protected by this Guaranty Association if:

- Their insurer was not authorized to do business in this state when it issued the policy or contract;
- Their policy was issued by a health care service plan (HMO), Blue Cross, Blue Shield, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.

The Guaranty Association also does not provide coverage for:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guaranty rights to group contract holders, not individuals;
- Employer and association plans, to the extent they are self-funded or uninsured;
- Synthetic guaranteed interest contracts;
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields that exceed an average rate;
- Any portion of a contract that provides dividends or experience rating credits.

### **Limits on Amount of Coverage**

The Act limits the Association to pay benefits as follows:

#### **Life and Annuity Benefits**

- 80% of what the life insurance company would owe under a life policy or annuity contract up to \$ 100,000 in cash surrender values, \$ 100,000 in present value of annuities, or \$ 250,000 in life insurance death benefits.
- A maximum of \$ 250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

#### **Health Benefits**

- A maximum of \$ 200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

### **Premium Surcharge**

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.



# Aetna Life Insurance Company



## Colorado Notice

### Summary of The Life And Health Insurance Protection Association Act And Notice Concerning Coverage Limitations And Exclusions

#### Introduction

Residents of Colorado who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Life and Health Insurance Protection Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Colorado and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is limited, however. As noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

#### Important Disclaimer

The Life and Health Insurance Protection Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require residency in Colorado. You should not rely on coverage by the Life and Health Insurance Protection Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy.

#### Summary

The state law that provides for this safety-net coverage is called the Life and Health Insurance Protection Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Association.

#### Coverage

Generally, individuals will be protected by the Life and Health Protection Association if they live in this state and hold a life or health insurance contract, or annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live in another state. Certain parties to structured settlement annuity contracts may be entitled to coverage benefits as well based on defined circumstances.

### **Exclusions from Coverage**

Persons holding such policies or contracts are not protected by this Association if:

- they are not residents of the State of Colorado, except under certain very specific circumstances;
- the insurer was not authorized or licensed to do business in Colorado at the time the policy or contract was issued;
- their policy was issued by a nonprofit hospital or health service corporation, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- plans of employers, associations or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- interest rates yields, crediting rate yields or other factors employed in calculating returns, including but not limited to indexes or other external references stated in the policy or contract, that exceed an average rate specified in the Association Act;
- dividends;
- experience rating credits;
- credits given in connection with the administration of a policy or contract;
- any unallocated annuity;
- annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
- policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
- sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
- unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- policies or contracts issued by an insurer which was insolvent or unable to fulfill its contractual obligations as of July 1, 1991, except for annuity contracts issued by a member insurer which was placed into liquidation between July 1, 1991 and August 31, 1991;
- policies or contracts covering persons who are not citizens of the United States;
- any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

### **Limits on Amount of Coverage**

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were issued by the same company, even if such contracts provided different types of coverages, the Association will pay a maximum of:

- \$ 300,000 in net life insurance death benefits and no more than \$ 100,000 in net cash surrender and net cash withdrawal values for life insurance;
- for health insurance benefits - \$ 100,000 for coverages not defined as disability, basic hospital, medical and surgical, or major medical insurance, including any net cash surrender and net cash withdrawal values: \$ 300,000 for disability insurance; or \$ 500,000 for basic hospital, medical and surgical, or major medical insurance;
- \$ 100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or
- with respect to each payee of a structured settlement annuity, \$ 100,000 in present value annuity benefits in the aggregate, including net cash surrender and net cash withdrawal values.

The Association shall not be liable to expend more than \$ 300,000 in the aggregate, with respect to any one life except that with respect to benefits for basic hospital, medical and surgical and major medical insurance, the aggregate liability of the association shall not exceed \$ 500,000 with respect to any one individual.

This Information is Provided By:

Life and Health Insurance Protection Association  
P.O. Box 480025  
Denver, CO 80248-0025  
(303) 292-5022

Colorado Division of Insurance  
1560 Broadway, Suite 850  
Denver, CO 80202  
(303) 894-7499

# Aetna Life Insurance Company



District of Columbia  
Life & Health Insurance Guaranty  
Association Act of 1992

## Summary of General Purposes And Current Limitations of Coverage

Residents of the District of Columbia who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in the District of Columbia to write these types of insurance are members of the District of Columbia Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the District of Columbia and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is limited, however, as noted below.

### Disclaimer

*The District of Columbia Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.** Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned on residence in the District of Columbia. Other conditions may also preclude coverage.*

*The District of Columbia Life and Health Insurance Guaranty Association or the District of Columbia Insurance Commissioner will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.*

*You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Act of 1992 when selecting an insurer.*

### *Policyholders with additional questions may contact:*

Mr. Robert M. Willis  
Executive Director  
District of Columbia Life and Health  
Insurance Guaranty Association  
1200 G Street, N.W.  
Washington, D.C. 20005  
(202) 434-8771  
Fax: (202) 347-2990

Mr. Thomas E. Hampton  
Commissioner  
District of Columbia Department  
of Insurance Securities and Banking  
810 First Street, N.E.  
Suite 701  
Washington, D.C. 20002  
(202) 727-8000

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810 First Street, NE, Suite 701 Washington, DC 20002 Tel: (202) 727-8000 <http://www.disb.dc.gov>

The District of Columbia law that provides for this safety-net coverage is called the Life and Health Insurance Guaranty Association Act of 1992. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in

connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

### **Coverage**

Generally, individuals will be protected by the District of Columbia Life and Health Insurance Guaranty Association if they live in the District of Columbia and are insured under a health insurance, life insurance, or annuity contract issued by a member insurer, or they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

### **Exclusions from Coverage**

However, persons holding such policies are not protected by this Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside of that state of incorporation);
- their insurer was not authorized to do business in the District of Columbia; or
- their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;
- interest rate guarantees which exceed certain statutory limitations;
- dividends, experience rating credits or fees for services in connection with a policy;
- credits given in connection with the administration of a policy by a group contract holder; or for
- unallocated annuity contracts.

### **Limits on Amount of Coverage**

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or,
- with respect to any one life, regardless of the number of policies, contracts, or certificates;
- \$ 300,000 in life insurance death benefits but not more than \$ 100,000 in net cash surrender or net cash withdrawal values for life insurance; or
- \$ 100,000 in health insurance benefits, including net cash surrender or net cash withdrawal values; or
- \$ 300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values.

Finally, in no event is the Guaranty Association liable for more than \$ 300,000 with respect to any one individual.

# Aetna Life Insurance Company



## **Notice Concerning Coverage Limitations And Exclusions Under The Hawaii Life And Disability Insurance Guaranty Association Act**

Residents of Hawaii who purchase life insurance, annuities or disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Hawaii Life and Disability Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

### **Disclaimer**

The Hawaii Life and Disability Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Hawaii. You should not rely on coverage by the Hawaii Life and Disability Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Hawaii Life and Disability Insurance Guaranty Association  
P.O. Box 4068  
Honolulu, Hawaii 96812

Department of Commerce & Consumer Affairs  
Insurance Division  
P.O. Box 3614  
Honolulu, Hawaii 96811

The state law that provides for this safety-net coverage is called the Hawaii Life and Disability Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

**Coverage**

Generally, individuals will be protected by the Hawaii Life and Disability Insurance Guaranty Association if they live in this state and hold a life or disability insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

**Exclusions from Coverage**

However, persons holding such policies are not protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state); or
- the insurer was not a member insurer of the Guaranty Association. A nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or an insurance exchange are examples of nonmember insurers.

The Guaranty Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals).

**Limits on Amount of Coverage**

The act also limits the amount the Guaranty Association is obligated to pay out: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$ 300,000--no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$ 300,000 limit, the Association will not pay more than \$ 100,000 in cash surrender values, \$ 100,000 in disability insurance benefits, \$ 100,000 in present value of annuities, or \$ 300,000 in life insurance death benefits --again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

# Aetna Life Insurance Company



## Summary of The Idaho Life And Health Insurance Guaranty Association Act And Notice Concerning Coverage Limitations And Exclusions

Revised July, 2005

Residents of Idaho who purchase life insurance, annuities or health/disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Idaho Life and Health Insurance Guaranty Association. The purpose of the Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for money to pay the claims of insured persons who reside in Idaho and, in some cases, to keep coverage in force. However, the protection provided by these insurers through the Association is limited and is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

The Idaho Life and Health Insurance Guaranty Association Act provides a safety net for certain purchasers of insurance. Below is a brief summary of the Act's coverage, exclusions and limitations. This summary does not cover all provisions of the Idaho Life and Health Insurance Guaranty Association Act, nor does it in any way change anyone's legal rights or obligations under the Act including the legal rights or obligations of the Association.

### Coverage

Generally, individuals will be protected by the Association if they live in Idaho and own a life or health/disability insurance policy, an annuity contract, or if they are an insured certificate holder under a group life or health insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of covered policies may be protected as well, even if they live in another state.

### Exclusions from Coverage

However, persons holding such policies or contracts are **not** protected by the Association if:

- They are eligible for protection under the laws of another state.
- The insurer was not authorized to do business in Idaho.
- The policy was issued by a reciprocal insurer, mutual benefit association, fraternal benefit society, hospital and medical service corporation, limited managed care plan, or self-funded health care plan.

The Association also does **not** provide coverage for:

- Any policy or contract or any portion of any policy or contract under which the risk is borne by the policyholder.
- Any policy of reinsurance.
- Interest rate yields that exceed an average rate.
- Unallocated annuity contracts (any annuity not issued to and owned by an individual).



### Limits on Amount of Coverage

The Act also limits the amount the Association is obligated to pay out. The Association cannot pay out more than what the insurance company would owe under a policy or contract. Furthermore, the amounts the Association is authorized to pay are limited as follows:

- Not more than \$ 100,000 of net cash surrender or net cash withdrawal values under a life insurance, health/disability insurance, or annuity policy or contract.
- Not more than \$ 300,000 of claims or benefit payments under a health/disability policy.
- Not more than \$ 300,000 of death benefits under a life insurance policy.
- Not more than \$ 300,000 of annuity benefit payments under a contract for which periodic annuity payments have begun to be paid, if the annuitization period chosen was the annuitant's lifetime or a period certain of 10 years or longer; otherwise \$ 100,000 of annuity benefit payments.
- **However, in no event will the Association be obligated to cover more than \$ 300,000 in the aggregate for all benefits for any one life.**

### Important Disclaimer

The Idaho Life and Health Insurance Guaranty Association does not provide coverage for all types of policies. In addition, coverage may be subject to substantial limitations or exclusions, and require continued residency in Idaho. You should not rely on coverage by the Idaho Life and Health Insurance Guaranty Association in selecting an insurance company or an insurance policy.

Coverage is not provided by the Idaho Life and Health Insurance Guaranty Association for your policy or contract or any portion of it that is not guaranteed by the insurer or for which the risk is borne by you - the policyholder.

Insurance companies and their agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any kind of insurance policy.

This Summary does not cover all provisions of the Idaho Life and Health Insurance Guaranty Association Act, nor does it in any way change your legal rights or obligations or the Association's legal rights or obligations which are defined by and set forth under the Act.

Idaho Life & Health Insurance Guarantee Association  
8324 Northview, Suite 104  
Boise, Idaho 83704  
208-378-9510  
[www.idlifega.org](http://www.idlifega.org)

Idaho Department of Insurance  
700 West State Street  
P.O. Box 83720  
Boise, Idaho 83720-0043  
208-334-4250  
1-800-721-3272  
[www.doi.idaho.gov](http://www.doi.idaho.gov)

# Aetna Life Insurance Company



## Illinois Life And Health Insurance Guaranty Association Law

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

### Illinois Life And Health Insurance Guaranty Association

#### *Disclaimer*

The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.** Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

Illinois Life and Health Insurance Guaranty Association  
8420 West Bryn Mawr Avenue  
Chicago, Illinois 60631  
(312) 714-8050

Illinois Department of Insurance  
320 West Washington Street 4<sup>th</sup> Floor  
Springfield, Illinois 62767  
(217) 782-4515

### Summary of General Purposes And Current Limitations of Coverage

The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law") (215 ILCS 5/531.01, et seq.). The following contains a brief summary of the Law's coverages, exclusions and limits. This summary does not cover all provisions; nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

**A) Coverage:**

The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:

- 1) life insurance, health insurance, and annuity contracts;
- 2) life, health or annuity certificates under direct group policies or contracts;
- 3) unallocated annuity contracts; and
- 4) contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees, or assignees of such persons are also protected, even if they live in another state.

**B) Exclusions from Coverage:**

- 1) The Guaranty association does not provide coverage for:
  - a) any policy or portion of a policy for which the individual has assumed the risk;
  - b) any policy of reinsurance (unless an assumption certificate was issued);
  - c) interest rate guarantees which exceed certain statutory limitations;
  - d) certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or government lottery;
  - e) any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
  - f) any stop loss insurance.
2. In addition, persons are not protected by the Guaranty Association if:
  - a) the Illinois Director of insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
  - b) their policy was issued by an organization which is not a member insurer of the Association.

**C) Limits on Amount of Coverage:**

1. The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty Association's liability is limited to the lesser of either:
  - a) the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or
  - b) with respect to any one life, regardless of the number of policies, contracts, or certificates:
    - i) in the case of life insurance, \$ 300,000 in death benefits but not more than \$ 100,000 in net cash surrender or withdrawal values;
    - ii) in the case of health insurance, \$ 300,000 in health insurance benefits, including net cash surrender or withdrawal values; and
    - iii) with respect to annuities, \$ 100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and \$ 100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is \$ 5,000,000 in benefits per contract holder, regardless of the number of contracts.

However, in no extent is the Guaranty Association liable for more than \$ 300,000 with respect to any one individual.

# Aetna Life Insurance Company



## Policyholder Notice:

**To:** Policyholders with Group Policies Issued in the State of Georgia

**Subject:** Breast Cancer Patient Care Act

The Georgia legislature has passed HB 604. This law requires us to inform you that:

- Your medical plan provides coverage for inpatient confinements following a mastectomy or a lymph node dissection;
- The length of such confinement will be determined by the attending physician in consultation with the patient; and
- The number of visits required for follow-up care after such surgery will be determined by the attending physician in consultation with the patient.

If you have any questions regarding this notice, please contact your Aetna account representative.

Georgia

# Aetna Life Insurance Company



**General Purposes And  
Limitations of The Kansas  
Life And Health Insurance  
Guaranty Association**  
K.S.A. 40-3001, et. Seq.

## **Disclaimer**

The Kansas Life and Health Insurance Guaranty Association may not provide coverage for all or a portion of this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and is dependent upon continued residence in Kansas. Therefore, you should not rely upon coverage by the Kansas Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Insurance companies and their agents are prohibited by law from using the existence of the Kansas Life and Health Insurance Guaranty Association in selling you any form of an insurance policy, or to induce you to purchase any form of an insurance policy. Either the Kansas Life and Health Insurance Guaranty Association or the Kansas Insurance Department will respond to any questions you have regarding this document.

**The Kansas Life and Health Insurance Guaranty Association**  
2909 SW Maupin Lane  
Topeka, KS 66614-5335

**The Kansas Insurance Department**  
420 Southwest 9<sup>th</sup> Street  
Topeka, KS 66612-1678

This is a summary of the basic provisions of the Kansas Life and Health Insurance Guaranty Association Act. It is only a summary, and does not provide an in depth analysis of that act. Nothing in this summary modifies the rights of persons who are protected by the act, or the rights or duties of the association.

The purpose of the Kansas Life and Health Insurance Guaranty Association Act is to protect certain individuals who purchase life insurance, annuities or health insurance in Kansas. The act provides for the establishment of a funding mechanism to pay benefits or provide insurance coverage to individuals when a life or health insurance company is unable to meet its obligations by reason of insolvency or financial impairment. However, not all individuals with a right to recover under life or health insurance policies are protected by the act. An individual is only provided protection when:

1. the individual, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, is the beneficiary, assignee or payee of a covered policy or contract holder,
2. the individual policy or contract holder is a resident of the state of Kansas,
3. the individual is not a resident of the state of Kansas, but only with respect to an annuity contract which has been awarded pursuant to a judgment or settlement agreement in a medical malpractice liability action,
4. the individual is not a resident of the state of Kansas, but only under all of the following conditions:
  - a. the impaired or insolvent insurer was a Kansas domestic insurer; and
  - b. the insurer never had a license to do business in the state in which the individual resides; and
  - c. the state in which the individual resides has an association similar to this state's; and
  - d. the individual is not eligible for coverage by the association of the state in which the individual resides.

Additionally, the association may not provide coverage for the entire amount the individual expects to receive from the policy. The association does not provide coverage for any portion of the policy where the individual has assumed the risk, for any policy of reinsurance, for interest rates that exceed a specified average rate, for employers' plans that

are self funded, for parts of plans that provide dividends or credits in connection with the administration of the policy, for policies sold by companies not authorized to do business in Kansas, or for any unallocated annuity contract or for policies or contracts that provide benefits under Medicare Part C or Part D. Also, the association will not provide coverage where any guaranty protection is provided to the individual under the laws of the insolvent or impaired insurer's state of domicile.

The act also limits the amount the association is obligated to pay individuals on various policies to those limits in effect on the date the association became liable for that impaired or insolvent insurer. The association does not pay more than the amount of the contractual obligation of the insurance company. Regardless of the number of policies or contracts the association is not obligated to pay amounts over \$ 300,000 in life insurance death benefits; \$ 100,000 in net cash surrender and net cash withdrawal values for life insurance, \$ 100,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, \$ 250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, unless the annuity contract is awarded pursuant to a judgment or settlement agreement in a medical malpractice liability action; or more than \$ 300,000 in the aggregate for the above coverage's with respect to any one life.

# Aetna Life Insurance Company



## Summary of The Louisiana Life And Health Insurance Guaranty Association Act And Notice Concerning Coverage Limitations And Exclusions

Residents of Louisiana who purchase life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the Guaranty Association is limited. As noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

### Disclaimer

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA  
P.O. Drawer 44126  
Baton Rouge, LA 70804

Department of Insurance  
P.O. Box 94214  
Baton Rouge, LA 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law. The following is a brief summary of the Law's coverage, exclusions and limits. This summary does not cover all provisions of the Law; nor does it in any way change any person's rights or obligations under the Law or the rights or obligations of the Guaranty Association.

### Coverage

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are protected as well even if they live in another state.

## **Exclusions from Coverage**

1. However, persons holding such policies are not protected by this Association if:
  - a. they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
  - b. the insurer was not authorized to do business in this state;
  - c. their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.
2. The Association also does not provide coverage for:
  - a. any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
  - b. any policy of reinsurance (unless an assumption certificate was issued);
  - c. interest rate yields that exceed an average rate;
  - d. dividends;
  - e. credits given in connection with the administration of a policy by a group contract holder;
  - f. employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
  - g. unallocated annuity contracts (which give rights to group contractholders, not individuals); unless qualified under § 403(b) of the Internal Revenue Code, except that, even if qualified under § 403(b), unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered;
  - h. any obligation that does not arise under the express written terms of this policy or contract;
  - i. any policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C or Part D coverage.

Other exclusions may also be applicable depending upon the issuing insurer, the policy itself, the policyholder or policy owner, or other factors. For more information, see the Louisiana Life and Health Insurance Guaranty Law, Louisiana Revised Statutes R.S. 22:2081 *et seq.*

## **Limits on Amount of Coverage**

The Law also limits the amount the Association is obligated to pay out: The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of \$ 500,000, no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall \$ 500,000 limit, the Association will not pay more than \$ 100,000 in cash surrender values, \$ 500,000 in health insurance benefits, \$ 250,000 in present value of annuities, or \$ 300,000 in life insurance death benefits-- again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.



# Aetna Life Insurance Company



## **Maryland notice concerning Coverage limitations and exclusions under the Life and health insurance guaranty corporation subtitle**

Residents of this State who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this State to write these types of insurance are members of the Maryland Life and Health Insurance Guaranty Corporation. The purpose of this is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty corporation will assess its other member insurance companies for the money to pay the claims of insured persons who live in this State and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty corporation is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Maryland Life and Health Insurance Guaranty Corporation may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Maryland. You should not rely on coverage by the Maryland Life and Health Insurance Guaranty Corporation in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their insurance producers are required by law to give or send you this notice. However, insurance companies and their insurance producers are prohibited by law from using the existence of the guaranty corporation to induce you to purchase any kind of insurance policy.

The Maryland Life and Health Insurance  
Guaranty Corporation  
9199 Reistertown Road  
P.O. Box 671t -- Suite 216C  
Owings Mills, Maryland 21117  
(410) 998-3907

The State law that provides for this safety-net is called the Life and Health Insurance Guaranty Corporation.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

Following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the law or the rights or obligations of the guaranty corporation.

### **Coverage**

Generally, individuals will be protected by the Life and Health Guaranty Corporation if they live in this State and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

### **Exclusions from Coverage**

However, persons owning such policies are not protected by this corporation if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this State;
- their policy was issued by a Health Maintenance Organization, a fraternal benefit society, a mandatory State pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessment, or by an insurance exchange.

The corporation also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance, unless assumption certificates have been issued);
- interest rate yields that exceed an average rate;
- any portion of a policy or contract to the extent that it provides dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals).

### **Limits on Amount of Coverage**

The statute also limits the amount the corporation is obligated to pay. The corporation cannot pay more than the amount the insurance company would owe under a policy or contract. Also, with respect to any one insured life, regardless of the number of policies or contracts with the member insurer, the corporation will pay a maximum of:

- \$ 300,000 in life insurance death benefits, but will not pay more than \$100,000 in life insurance cash surrender values;
- \$ 300,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values; and
- \$ 100,000 in the present value of annuity benefits, including any net cash surrender and net cash withdrawal values.

These amounts are the maximums, no matter how many policies and contracts the insured has with the member company.

# Aetna Life Insurance Company

151 Farmington Avenue  
Hartford, CT 06156



## Notice Concerning Policyholder Rights In An Insolvency Under The Minnesota Life And Health Insurance Guaranty Association Law

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, **SUBJECT TO LIMITS AND EXCLUSIONS**, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

MINNESOTA LIFE AND  
HEALTH INSURANCE GUARANTY ASSOCIATION  
4640 West 77<sup>th</sup> Street, Suite 342  
Edina, Minnesota 55435  
(612) 831-1908

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to \$ 300,000. Subject to this \$ 300,000 limit, the guaranty association will pay up to \$ 300,000 in life insurance death benefits, \$ 100,000 in net cash surrender and net cash withdrawal values for life insurance, \$ 300,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, \$ 100,000 in annuity net cash surrender and net cash withdrawal values, \$ 300,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be \$ 300,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, [FN1] as amended through December 31, 1992, are covered up to \$ 100,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than \$ 7,500,000 in claims from all Minnesota residents covered by the plan. If total claims exceed \$ 7,500,000, the \$ 7,500,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

**THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.**

**THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.**

**NOTICE TO POLICYHOLDER CONCERNING AVAILABILITY OF  
“QUALIFIED PLANS”**

The accident and health insurance included in this policy does not constitute a “qualified plan” as defined by Minnesota statute. Aetna does offer insurance plans that are qualified plans. Qualified plans provide coverage for major medical expense, as defined by Minnesota statute. Information is available upon request.

# Aetna Life Insurance Company



## Missouri Notice Concerning Coverage Limitations And Exclusions Under The Life And Health Insurance Guaranty Association Act

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Missouri Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Missouri Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Missouri. You should not rely on coverage by the Missouri Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy. Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. Insurance companies or their insurance producers are required by law to give or send you this notice. However, insurance companies and their insurance producers are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy. **You May Contact Either The Association or The Missouri Department of Insurance At The Following Addresses Should You Have Any Questions Regarding This Notice.**

The Missouri Life and Health Insurance Guaranty Association  
520 Dix Road, Suite D  
Jefferson City, MO 65109

Missouri Insurance Department  
P.O. Box 690  
Jefferson City, MO 65109

The state law that provides for this safety-net is called the Missouri Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the guaranty association.

Generally, persons will be covered if they live in this state, and hold a life or health insurance contract or annuity, or a certificate under a group policy or contract. However, not all individuals with a right to recover under life or health insurance policies or annuities are protected by the Act. A person is not protected when:

1. The person is eligible for protection under the laws of another state;
2. The person purchased the insurance from a company that was not authorized to do business in this state;
3. The policy is issued by an organization which is not a member insurer of the association; or
4. The person does not live in this state, except under limited circumstances.

Additionally, the Association may not provide coverage for the entire amount a person expects to receive from the policy. The Association does not provide coverage for any portion of the policy where the person has assumed the risk, for any policy of reinsurance (unless an assumption certificate was issued), for interest rates that exceed a specified average rate, for employers' plans that are self-funded, for parts of plans that provide dividends or credits in connection with the administration of policy, or for unallocated annuity contracts (which are generally issued to pension plan trustees). The Act also limits the amount the Association is obligated to pay persons on various policies. The Association does not pay more than the amount of the contractual obligation of the insurance company. The Association does not have to pay more than three hundred thousand dollars (\$ 300,000) in death benefits for any one life regardless of the number of policies that insure that life. The Association does not have to pay amounts over one hundred thousand dollars (\$ 100,000) in cash surrender or withdrawal benefits on one life regardless of the number of policies insuring that individual. For health insurance benefits, the Association is not obligated to pay over one hundred thousand dollars (\$ 100,000) including net cash surrender and withdrawal benefits. On an annuity contract, the Association is not liable for over one hundred thousand dollars (\$ 100,000) in present value. Finally, the Association is never obligated to pay more than a total of three hundred thousand dollars (\$ 300,000) for any one insured for any combination of insurance benefits.

# Aetna Life Insurance Company



## Summary of Mississippi Life And Health Insurance Guaranty Association Act And Notice Concerning Coverage

### Limitations and Exclusions

Residents of this state who purchase life insurance, health insurance, or annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the Mississippi Life and Health Insurance Guaranty Association (the "Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

### Disclaimer

The Mississippi Life and Health Insurance Guaranty Association (the "Guaranty Association") may not provide coverage for this policy. If coverage is provided, it will be subject to substantial limitations and exclusions, and require continued residency in this state. You should not rely on coverage by the Guaranty Association when selecting an insurer.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. You may contact either the Guaranty Association or the Mississippi Insurance Department at the following addresses if you should have any questions regarding this notice.

The Mississippi Life and Health Insurance Guaranty Association  
300 North Mart Plaza, Suite 2  
Jackson, Mississippi 39206

Mississippi Insurance Department  
1804 Walter Sillers Building  
Jackson, Mississippi 39205

The state law that provides for this safety-net coverage is called the Mississippi Life and Health Insurance Guaranty Association Act (the "Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

## Coverage

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, or health insurance contract or policy, or an annuity contract or policy, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

## Exclusions from Coverage

However, persons owning such policies are NOT protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy or contract was issued by a hospital or medical service organization whether profit or nonprofit, a health maintenance organization (HMO), a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or other person that operates on an assessment basis, an insurance exchange, or any similar entity.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy or contract of reinsurance, unless an assumption certificates were issued pursuant to the reinsurance policy or contract;
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits or payment of any fees or allowances to any person in connection with this service to or administration of the policy or contract;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts issued to or in connection with benefit plans protected under federal Pension Benefit Guaranty Corporation ("PBGC") regardless of whether the PBGC has yet become liable to make any payments with respect to the benefit plan;
- Portions of any unallocated annuity contract not issued to or in connection with a specific employee, union or association of natural persons benefit plan, or a government lottery;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association with respect to the policy or contract are preempted by State or Federal law;
- Obligations that do not arise under the express written terms of the policy or contract, including claims based on marketing materials, side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements, or claims for policy misrepresentations, or extra-contractual or penalty or consequential or incidental damages claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).



**Limits on Amount of Coverage**

The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, with respect to any one life, regardless of the number of policies or contracts, the maximum obligation of the Guaranty Association is \$ 300,000 in benefits except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance in which case the aggregate liability of the Guaranty Association is \$ 500,000. Within these overall limits, the Guaranty Association will not pay more than \$ 300,000 in life insurance death benefits, \$ 100,000 in net cash surrender and net cash withdrawal values, \$ 300,000 for disability insurance benefits, \$ 500,000 for basic hospital, medical and surgical insurance or major medical insurance benefits, \$ 100,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$ 5,000,000 limit with respect to any contract owner for unallocated annuity benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or to the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

# Aetna Life Insurance Company



## **Notice Concerning Coverage Limitations And Exclusions Under The North Carolina Life And Health Insurance Guaranty Association Act**

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholder will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association  
Post Office Box 10218  
Raleigh, North Carolina 27605-0218

North Carolina Department of Insurance, Consumer Services Division  
1201 Mail Service center  
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

### **Coverage**

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

### **Exclusions from Coverage**

However, persons owning such policies are not protected by the association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

### **Limits on Amount of Coverage**

The act also limits the amount the association is obligated to pay out as follows:

- (1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
- (2) Except as provided in (4) and (5) below, the guaranty association will pay a maximum of \$300,000 per individual, per insolvency, no matter the number of policies or types of policies issued by the insolvent company.
- (3) Except as provided in (4) and (5) below, the guaranty association will pay an aggregate maximum of \$500,000 with respect to any one individual affected by multiple insolvencies.
- (4) The guaranty association will pay a maximum of \$1,000,000 with respect to any one structured settlement annuity contract holder.
- (5) The guaranty association will pay a maximum of \$5,000,000 to any one unallocated annuity contract holder.

# Aetna Life Insurance Company



## Summary of The 1996 New Hampshire Life And Health Insurance Guaranty Association Act (RSA 408-B) And Notice Concerning Coverage Limitations And Exclusions

Residents of New Hampshire who purchase life insurance, health insurance, and annuities should know that the insurance companies licensed in New Hampshire to write these types of insurance are members of the New Hampshire Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the claims of policyholders who live in New Hampshire and, in some cases, to keep coverage in force. This protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

### Important Disclaimer

The New Hampshire Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Hampshire. Other conditions may preclude coverage.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to provide you with this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy.**

This information is provided by:

New Hampshire Life and Health Insurance Guaranty Association  
47 Hall Street, Suite 2  
Concord, NH 03301  
(603) 226-9114

New Hampshire Department of Insurance  
21 South Fruit Street, Suite 14  
Concord, NH 03301  
(603) 271-2261

### Summary:

The 1996 state law that provides for this safety-net coverage is called the New Hampshire Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

**Coverage:**

Generally, individuals will be protected by the New Hampshire Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance policy or an annuity contract, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, assignees or payees of insured persons are protected as well, even if they live in another state.

Coverage provided under this Act may be different from coverage provided prior to 1996, as coverage is determined by the governing Act in effect on the date that the Association becomes obligated.

**Exclusions from Coverage:**

Persons holding such policies or contracts are NOT protected by this Association if:

- they are not residents of the state of New Hampshire, except under certain very specific circumstances;
- they are eligible for protection under the laws of another state;
- their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or an entity that operates on an assessment basis, an insurance exchange, or any entity similar to any of the above.

The Association also does NOT provide coverage for:

- any policy or portion of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policy holder or contract holder;
- any policy or contract of reinsurance, unless assumption certificates have been issued;
- interest rate guarantees that exceed certain statutory limitations;
- any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or similar entity;
- dividends, experience rating credits, or fees for services in connection with this policy;
- any policy or contract issued in this state by an insurer at a time when it was not licensed or authorized to do business in New Hampshire;
- any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law.

**Limits on Amount of Coverage:**

The Act also limits the amount the Association is obligated to pay: The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one life, the Association will pay a maximum of \$ 300,000--no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$ 300,000 limit, the Association will not pay more than \$ 100,000 in cash surrender values, \$ 100,000 in health insurance benefits, \$ 100,000 in present value of annuities, or \$ 300,000 in life insurance death benefits.

With respect to any one contract holder of an unallocated annuity contract, not including a governmental retirement plan established under Section 401, 403(b) or 457 of the U.S. Internal Revenue code, the Association will pay a maximum of \$ 5,000,000 in benefits, irrespective of the number of such contracts held by that contract holder.

**Additional Information:**

Policyholders should contact the New Hampshire Insurance Department with questions they may have with regard to concerns about their rights under the Act and procedures for filing a complaint to allege a violation of the Act.

Policyholders may contact the New Hampshire Insurance Department for sources of information about the financial condition of insurers.

# Aetna Life Insurance Company



## Nevada Life And Health Insurance Guaranty Association Act Summary Document

Residents of Nevada who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Nevada Life and Health Insurance Guaranty Association (Guaranty Association). The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association assesses its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, and, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

**The Nevada Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations and exclusions, and require continued residency in Nevada. A person should not rely on coverage by the Nevada Life and Health Insurance Guaranty Association when selecting an insurance company or when selecting an insurance policy.**

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the Insurer or for which the policyholder has assumed the risk, such as a variable contract sold by prospectus.

Insurance companies are required by law to deliver this notice to you. **However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association for sales, solicitation or to induce the purchase of any kind of insurance policy.**

The state law that provides for this safety-net coverage is called the Nevada Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association. **Anyone may obtain additional information or file a complaint with the Commissioner of Insurance, at the address listed below, to allege a violation of any provision of the Nevada Life and Health Insurance Guaranty Association Act.**

**The Nevada Life and Health Insurance Guaranty Association  
P.O. Box 3302  
Reno, Nevada 89505**

**Commissioner of Insurance, State of Nevada  
Department of Business and Industry, Division of Insurance  
788 Fairview Drive, Suite 300  
Carson City, Nevada 89701-5491**

## Coverage

Generally, individuals will be protected by the Nevada Life and Health Insurance Guaranty Association if they live in this state and **hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract issued by a member insurer.** The beneficiaries, payees or assignees of insured persons are protected as well even if they live in another state.

## Exclusions from Coverage

However, persons holding such policies are **not** protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside the state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a nonprofit hospital or medical service organization (the "Blues"), a health maintenance organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals).

## Limits on Amount of Coverage

The act also limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of \$ 300,000, regardless of how many policies and contracts there were with the same company, and even if they provided different types of coverage. Within this overall \$ 300,000 limit, the Association will not pay more than \$ 100,000 in cash surrender values, \$ 100,000 in present value of annuities, or \$ 300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

With respect to health insurance for any one natural person, the Association will not pay more than: 1) \$ 100,000 for coverage other than disability insurance, basic hospital, medical and surgical insurance or major medical insurance, including any net cash surrender or withdrawal; 2) \$ 300,000 for disability insurance; or 3) \$ 500,000 for basic hospital, medical and surgical insurance or major medical insurance.

With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, the Association will not pay more than \$ 100,000 in present value of benefits from the annuity in the aggregate, including any net cash for surrender or withdrawal.

With respect to any one life or person, in no event will the Association be obligated to cover more than: 1) an aggregate of \$ 300,000 in benefits, excluding benefits for basic hospital, medical and surgical insurance or major medical insurance; or 2) an aggregate of \$ 500,000 in benefits, including benefits for basic hospital, medical and surgical insurance or major medical insurance.

With respect to one owner of several nongroup policies of life insurance, whether the owner is a natural person or an organization and whether the persons insured are officers, managers, employees or other persons, the Association will not pay more than \$ 5,000,000 in benefits, regardless of the number of policies and contracts held by the owner.



# Aetna Life Insurance Company



**Ohio Life And Health Insurance  
Guaranty Association  
Disclaimer And Not Covered Form**

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

**Ohio Life and Health Insurance Guaranty Association  
1840 Mackenzie Drive  
Columbus, Ohio 43220**

**Ohio Department of Insurance**  
50 West Town Street, Third Floor – Suite 300  
Columbus, Ohio 43215

# Aetna Life Insurance Company



## Notice Concerning Coverage Limitations And Exclusions Under The Oklahoma Life And Health Insurance Guaranty Association Act

Residents of Oklahoma who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Oklahoma Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

**The Oklahoma Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Oklahoma. You should not rely on coverage by the Oklahoma Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.**

**Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.**

**Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.***

**The Oklahoma Life and Health Insurance Guaranty Association  
201 Robert S. Kerr, Suite 600  
Oklahoma City, Oklahoma 73102**

**Oklahoma Department of Insurance  
P.O. Box 53408  
Oklahoma City, Oklahoma 73152-3408**

The state law that provides for this safety-net coverage is called the Oklahoma Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

### Coverage

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

### **Exclusions from Coverage**

However, persons owning such policies are not protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals).

### **Limits on Amount of Coverage**

The act also limits the amount the Association is obligated to pay out: The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for one insured life, the Association will pay a maximum of \$ 300,000--no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$ 300,000 limit, the Association will not pay more than \$ 100,000 in cash surrender values, \$ 300,000 in health insurance benefits, \$ 300,000 in present value of annuities, or \$ 300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

# Aetna Life Insurance Company



## **Summary Coverage, Limitations and Exclusions Under Rhode Island Life and Health Insurance Guaranty Association Act ("Act")**

A resident of Rhode Island who purchases life insurance, annuities, long-term care, or accident and health insurance should know that an insurance company licensed in Rhode Island to write these types of insurance is a member of the Rhode Island Life and Health Insurance Guaranty Association ("Association"). The purpose of the Association is to assure that a policyholder will be protected within the statutory limits, if a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will, within the statutory limits, pay the claims of insured persons who live in this state, and, in some cases, keep coverage in force. However, the protection provided through the Association is not unlimited. This protection is not a substitute for your care in selecting a company that is well managed and financially stable.

### **Important Disclaimer**

Rhode Island Life And Health Insurance Guaranty Association  
235 Promenade Street, #426 Providence, RI 02908  
Tel (401) 273-2921

The Rhode Island Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.** Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in this state. Other conditions may also preclude coverage.

The Life and Health Insurance Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association when selecting an insurer.

Rhode Island Division Of Insurance  
1511 Pontiac Avenue, Cranston, RI 02920  
TEL (401) 462-9520

The full text of the state law that provides for this safety net coverage, Rhode Island Life and Health Insurance Guaranty Association Act, ("the Act"), can be found beginning at R.I. Gen. Laws §27-34.3-1. A brief summary of the Act is provided below. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations or those of the Association under the Act.

**Coverage:** Generally, individuals will be protected by the Association if the individual lives in Rhode Island and: Holds a life or health insurance contract, long-term care contract or annuity contract; or is insured under a group insurance contract issued by a member insurer. The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live elsewhere.

**Exclusions from Coverage:** The Association does NOT protect a person holding a policy if:

- the individual is eligible for protection under a similar law of another state;
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization that is not a member of the Association;
- the policy was issued by a nonprofit hospital or medical service organization (such as, the “Blues”), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments or by an insurance exchange.

The Association does not provide coverage for:

- a policy or portion of a policy not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus; a policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed a rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- an employer’s plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administrators the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer.
- a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D) or any regulations issued pursuant thereto.

**Limitations on Coverage:** The Act limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurer would have owed under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were in force with the same insurer, the Association will pay no more than:

- \$ 300,000 in net life insurance death benefits and no more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance;
- \$ 100,000 for health insurance benefits, coverages not defined as disability, basic hospital, medical, and surgical, or major medical insurance, or long-term care insurance including any net cash surrender and net cash withdrawal values;
- \$ 300,000 for disability insurance;
- \$ 300,000 for long-term care insurance;
- \$ 500,000 for basic hospital, medical, and surgical or major medical insurance;
- \$ 250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal value;
- \$ 250,000 in present value per payee with respect to a structured settlement annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;

- \$ 250,000, in the aggregate, of the present value of annuity benefits, including net cash surrender and net cash withdrawal values, with respect to an individual participating in a governmental retirement plan established under 26 U.S.C. §§401, 403(b), or 457 and covered by an unallocated annuity contract, or to a beneficiary of the individual if the individual is deceased;
- \$ 5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund governmental retirement plans under sections 401(k), 403(b), or 457 of the Internal Revenue Code, the limit is \$ 250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the Association be liable to spend more than \$ 300,000 in the aggregate per individual except hospital insurance up to \$ 500,000 per individual. For covered unallocated annuities that fund other plans, a special limit of \$ 5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, the contract limits also apply.

These general statements as to Limitations on Coverage are only summaries of the law. The actual limitations are set forth in R.I. Gen. Laws §27-34.3-3.

Any alleged violations of the provisions of the Rhode Island Life and Health Insurance Guaranty Association Act may be reported to the Rhode Island Division of Insurance at the address and telephone number above.

This information is provided by: The Association and by the Division of Insurance, whose respective addresses are provided in the Important Disclaimer, above.

# Aetna Life Insurance Company



## **Notice Concerning Coverage Limitations And Exclusions Under The Tennessee Life And Health Insurance Guaranty Association Act**

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

### **Coverage**

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

### **Exclusions from Coverage**

However, persons holding such policies are not protected by this association if:

- (1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- (2) the insurer was not authorized to do business in this state;
- (3) their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- (1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- (2) any policy of reinsurance (unless an assumption certificate was issued);
- (3) interest rate yields that exceed an average rate;
- (4) dividends;
- (5) credits given in connection with the administration of a policy by a group contractholder;

- (6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- (7) unallocated annuity contracts (which give rights to group contractholders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered.

### **Limits on Amount of Coverage**

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of \$ 300,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall \$ 300,000 limit, the association will not pay more than \$ 100,000 in cash surrender values, \$ 100,000 in health insurance benefits, \$ 100,000 in present value of annuities, or \$ 300,000 in life insurance death benefits -- again, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages.

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

**Tennessee Life And Health Insurance  
Guaranty Association**  
1200 First Union Tower 150 4<sup>th</sup> Avenue  
North Nashville, Tennessee 37219-2433

**Tennessee Department Of Commerce And Insurance**  
500 James Robertson Parkway  
Nashville, Tennessee 37243



# Aetna Life Insurance Company



Texas Life, Accident, Health & Hospital Service  
Insurance Guaranty Association

**Important Information About Coverage Under The Texas  
Life, Accident, Health And Hospital Service Insurance  
Guaranty Association  
(For Insurers Declared Insolvent or Impaired on or After September 1, 2005)**

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect Texas policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

**It is possible that the Association may not cover your policy in full or in part due to statutory limitations.**

## **Eligibility for Protection by the Association**

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at the time **(irrespective of the policyholder's residency at policy issue)**
- Residents of other states, ONLY if the following conditions are met:
  1. The policyholder has a policy with a company domiciled in Texas;
  2. The policyholder's state of residence has a similar guaranty association; and
  3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

## **Limits of Protection by Association**

### **Accident, Accident and Health, or Health Insurance:**

- For each individual covered under one or more policies; up to a total of \$500,000 for basic hospital, medical-surgical, and major medical insurance, \$300,000 for disability or long term care insurance, and \$200,000 for other types of health insurance.

### **Life Insurance:**

- Net cash surrender value or net cash withdrawal value up to a total of \$100,000 under one or more policies on any one life; or
- Death benefits up to a total of \$300,000 under one or more policies on any one life; or
- Total benefits up to a total of \$5,000,000 to any owner of multiple non-group life policies.

### **Individual Annuities:**

- Present value of benefits up to a total of \$100,000 under one or more contracts on any one life.

### **Group Annuities:**

- Present value of allocated benefits up to a total of \$100,000 on any one life; or
- Present value of unallocated benefits up to a total of \$5,000,000 for one contractholder regardless of the number of contracts.

Texas

**Aggregate Limit:**

- \$300,000 on any one life with the exception of the \$500,000 health insurance limit, the \$5,000,000 multiple owner life insurance limit, and the \$5,000,000 unallocated group annuity limit.

**Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage.**

Texas Life, Accident, Health and Hospital Service  
Insurance Guaranty  
Association  
6504 Bridge Point Parkway  
Suite 450  
Austin, Texas 78730  
800-982-6362 or  
[www.txlifega.org](http://www.txlifega.org)

Texas Department of Insurance  
P.O. Box 149104  
Austin, Texas 78714-9104  
800-252-3439  
[www.tdi.state.tx.us](http://www.tdi.state.tx.us)

# Aetna Life Insurance Company



## Utah Life and Health Insurance Guaranty Association Notice To Policyholders

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

### People Entitled To Coverage

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

### Policies Covered

ULHIGA provides coverage for certain life, health and annuity insurance policies.

### Exclusions and Limitations

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's guaranty association.
- Policies where the policyholder bears the risk under the policy.
- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

### Limits on Amount of Coverage

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or \$500,000 -- whichever is lower. Other caps also apply:

- \$ 200,000 in net cash surrender values.
- \$ 500,000 in life insurance death benefits (including cash surrender values).
- \$ 500,000 in health insurance benefits.
- \$ 200,000 in annuity benefits - if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- \$ 5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).

Interest rates on some policies may be adjusted downward.

## Disclaimer

### **Please Read Carefully:**

**Coverage From Ulhiga May Be Unavailable Under This Policy, or, If Available, It May Be Subject To Substantial Limitations or Exclusions. The Description of Coverages Contained in This Document is an Overview. It is Not a Complete Description. You Cannot Rely on This Document as a Description of Coverage. For a Complete Description of Coverage, Consult The Utah Code, Title 31a and Chapter 28.**

**Coverage Is Conditioned On Continued Residency In The State Of Utah.**

**The Protection That May Be Provided By Ulhiga Is Not A Substitute For Consumers' Care In Selecting An Insurance Company That Is Well-Managed And Financially Stable.**

**Insurance Companies And Insurance Agents Are Required By Law To Give You This Notice. The Law Does, However, Prohibit Them From Using The Existence Of Ulhiga As An Inducement To Sell You Insurance.**

**The Address Of Ulhiga, And The Insurance Department Are Provided Below.**

Utah Life and Health Insurance Guaranty Association  
955 E. Pioneer Road  
Draper, Utah 84020

Utah Insurance Department  
State Office Building  
Room 3110  
Salt Lake City, Utah 84114

# Aetna Life Insurance Company



## Important Information Regarding Your Insurance

**To:** Policyholders with Group Policies Issued in the State of Virginia

**Subject:** Insurance Contact Notice

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

Aetna Life Insurance Company  
151 Farmington Avenue  
Hartford, CT 06156  
1-800-872-3862

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at the following address and telephone number:

Virginia Bureau of Insurance  
P.O. Box 1157  
Richmond, Virginia 23218  
Consumer Service Hotline (Toll Free and Nationwide):  
877-310-6560

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Virginia

# Aetna Life Insurance Company



## **Notice Concerning Coverage Limitations And Exclusions Under The West Virginia Life And Health Insurance Guaranty Association Act**

Residents of West Virginia who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the West Virginia Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The West Virginia Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in West Virginia. You should not rely on coverage by the West Virginia Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy. For a complete description of coverage, consult Article 26A, Chapter 33 of the West Virginia Code.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Guaranty Association or the West Virginia Insurance Commission will respond to questions you may have which are not answered by this document. Policyholders with additional questions may contact:

West Virginia Life and Health Insurance Guaranty Association  
P.O. Box 816  
Huntington, West Virginia 25712

West Virginia Insurance Commissioner  
Consumer Services Division  
1124 Smith Street, Room 309  
P.O. Box 50540  
Charleston, West Virginia 25305-0540  
(304) 558-3386  
Toll Free 1-800-642-9004  
TDD 1-800-435-7381

The state law that provides for this safety-net coverage is called the West Virginia Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

Generally, individuals will be protected by the West Virginia Life and Health Insurance Guaranty Association if they live in West Virginia and hold a life or health insurance contract, annuity contract, unallocated annuity contract, or if they are insured under a group life, health or annuity insurance contract, issued by a member insurer. Member insurer also includes non-profit service corporations and health care corporations. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

### **Exclusions from Coverage**

However, persons holding such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy was issued at a time when the insurer was not licensed or authorized to do business in the state;
- their policy was issued by an HMO, a fraternal benefit society, mandatory state pooling plan, a mutual protective association or similar plan in which the policyholder is subject to future assessments, an insurance exchange, or an entity similar to the above.

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual or contract holder has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employer or association plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured, including:
  - i. multiple employer welfare arrangement;
  - ii. minimum premium group insurance plan;
  - iii. stop loss group insurance plan; or
  - iv. administrative services only contract.
- any unallocated annuity contract issued to an employee benefit plan protected under the federal pension guaranty corporation;
- any portion of any unallocated contract which is not issued to or in connection with a specific employee, union or association's benefit plan or a governmental lottery.

### **Limits on Amount of Coverage**

The act also limits the amount the Guaranty Association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of \$ 300,000--no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$ 300,000 limit, the association will not pay more than \$ 100,000 in cash surrender values, \$ 100,000 in health insurance benefits, \$ 100,000 in present value of annuities, or \$ 300,000 in life insurance death benefits --again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: for unallocated annuities that fund governmental retirement plans under sections 401(k), 403(b) or 457 of the Internal Revenue Code, the limit is \$ 150,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than \$ 300,000 in the aggregate per individual; for covered unallocated annuities that fund other plans, a special limit of \$ 1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

# Aetna Life Insurance Company



## **Notice Concerning Coverage Limitations And Exclusions Under The Wyoming Life And Health Insurance Guaranty Association Act**

Residents of Wyoming who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Wyoming Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Wyoming Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Wyoming. You should not rely on coverage by the Wyoming Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association for the purpose of sales or to induce you to purchase any kind of insurance policy.

The Wyoming Life and Health Insurance Guaranty Association  
P.O. Box 480164  
Denver, CO 80248

State of Wyoming  
Department of Insurance  
Herschler Building  
122 West 25<sup>th</sup> Street  
Cheyenne, WY 82002-0440

The state law that provides for this safety-net coverage is called the Wyoming Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

### **Coverage**

Generally, individuals will be protected by the Wyoming Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.



### **Exclusions from Coverage**

However, persons owning such policies are *not* protected by this Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a stipulated premium insurance company, a local mutual burial association, a mutual assessment company or similar plan in which the policyholder is subject to future assessment, or by an insurance exchange.

The Association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends;
- Credits given in connection with the administration of a policy by a group contract holder;
- Annuity contracts issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees;
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured.

### **Limits on Amount of Coverage**

The act also limits the amount the Association is obligated to pay out: The Association cannot pay more than the amount the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of \$ 300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$ 300,000 limit, the Association will not pay more than \$ 100,000 in cash surrender values for life insurance policies, \$ 100,000 in health insurance benefits, \$ 100,000 in present value of annuities, or \$ 300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.



## Group Accident and Health Insurance Policy

This Policy is entered into by and between

**Aetna Life Insurance Company**  
(Aetna, We, Us, or Our)

and

**Dell Inc.**  
(the Policyholder)

Policy Number: GP-476626  
Date of Issue: January 1, 2009  
Effective Date: January 1, 2009

This Policy shall be effective on the Effective Date and shall continue in force until terminated as provided herein.

In consideration of the mutual promises hereunder and the payment of Premiums and fees when due, We will pay benefits in accordance with the terms, conditions, limitations and exclusions set forth in this Policy. Benefits will be paid in accordance with the reasonable exercise of Our business judgment, consistent with applicable law. The duties and the rights of all persons will be based solely on the terms of this Policy.

Upon receipt of the Policyholder's signed Group Application, and upon receipt of the required initial Premium, this Policy shall be considered to be agreed to by the Policyholder and Us, and is fully enforceable in all respects against the Policyholder and Us.

Term of Policy: The Initial Term shall be:  
The 12 consecutive month period beginning on the Effective Date.  
Thereafter, Subsequent Terms shall be:  
The 12 consecutive month period beginning on January 1 of each year.  
Premium Due Dates: The Effective Date and the first day of each succeeding calendar month.

**THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCURE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.**

This Policy is non-participating.

This Policy is governed by applicable federal law and the laws of Texas.

Signed at Aetna's Home Office 151 Farmington Avenue Hartford, Connecticut 06156 on the date of issue.

GR-29N  
01-01  
01 TX



Ronald A. Williams  
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

# **Aetna Life Insurance Company**

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# Special Notice

## Important Information Regarding Your Insurance

### Insurance Contact Notice

In the event you need to contact someone about this insurance for any reason please contact your sales agent or broker. If no sales agent or broker was involved in the sale of this insurance, or if you have additional questions you may contact Us at the following address and telephone number:

**Aetna** Life Insurance Company  
151 Farmington Avenue  
Hartford, CT 06156  
1-800-872-3862

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your sales agent, broker or Us, have your policy number available.

### Fraud Notice

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

## Definitions (GR-29N 03-01 01 TX)

**Employee.** This term is defined in the *Eligibility, Enrollment and Effective Date of Your Coverage* Section of the Certificate.

If the Policyholder is a partnership or proprietorship, each of its natural-person partners, or the proprietor, will be deemed to be an employee.

If an eligible person is covered under any other group health plan issued to the Policyholder by Us, or any other health benefit plan established and maintained by the Policyholder, they will not be considered eligible for health coverage under this Policy.

An employee is eligible only for the coverages shown in the Certificate which applies to his or her class.

# Policy Contents

This Policy consists of all provisions set forth in this document as well as the provisions found in the Certificate, including the *Schedule of Benefits*, issued to covered employees under the group plan. Any amendment changing the provisions of the Certificate is also made part of this Policy as of the effective date of the amendment.

Certificate means each certificate included in the Policy as follows:

Identification	Issue Date	Effective Date	Eligible Group and/or Type of Coverage
Cert 1	January 1, 2009	January 1, 2009	LTD
SOB1A	January 1, 2009	January 1, 2009	LTD
Rider 1	January 1, 2009	January 1, 2009	Appeals Rider

## Premiums and Fees (GR-29N 05-01 01 TX) (GR-9N 29-005-01-TX)

**Premiums Rates.** The premium charges will be determined in accordance with the Premium Rates in effect on the Premium Due Date. The initial monthly Premium Rates are set forth in the Schedule of Premiums and Fees.

However, any other method may be used which: (a) yields about the same total amount; and (b) is agreeable to both the Policyholder and Us.

**Premiums Due – Experience Rating.** The Premium due under this policy on any Premium Due Date will be the sum of the premium charges for the coverages provided under this Policy. Covered employees and dependents as of each Premium Due Date will be determined by Us in accordance with Our records. A check does not constitute payment until it is honored by a bank. We may return a check issued against insufficient funds without making a second deposit attempt. We may accept a partial payment of Premium without waiving our right to collect the entire amount due.

If premiums are payable monthly, any insurance becoming effective will be charged from the first day of the policy month on or right after the date the insurance takes effect. Premium charges for insurance which terminates will cease as of the first day of the policy month on or right after the date the insurance terminates. If premiums are payable less often than monthly, premium charges or credits for a fraction of a premium-paying period will be made on a pro rata basis for the number of policy months between the date premium charges start or cease and the end of the premium-paying period. If this policy is changed to provide more coverage to take effect on a date other than the first day of a premium-paying period, a pro rata premium for the coverage will be due and payable on that date. It will cover the period then starting and ending right before the start of the next premium-paying period.

We may change premiums due to experience or a change in factors bearing on the risk assumed. Each change shall be made by written notice to the Policyholder by Us pursuant to *Changes in Premium* section.

No experience reduction or increase in Premium Rates shall become effective less than 12 months after the effective date of this Policy.

At the end of a policy year, We may declare an experience credit. The amount of each credit We declare will be returned to the Policyholder. Upon request by the Policyholder, part or all of it will be applied against payment of premiums or in any other manner as agreed to by the Policyholder and Us.

Instead of figuring premiums as described above, premiums may be figured in any way approved by Us that comes up with about the same amount of premiums.

(GR29N 05-02 01 TX)

**Aetna** will not have to refund any premium for a period prior to:

- The first day of the policy year in which **Aetna** receives proof that the refund should be made; or
- The date 3 months before **Aetna** receives proof, if this produces a larger refund.

This applies even if the premium was paid in error.

**Fees.** In addition to the Premium, We may charge the following fees:

- An installation fee may be charged upon initial installation of coverage or any significant change in installation (e.g., a significant change in the number of employees or a change in the method of reporting employee eligibility to Us). A fee may also be charged upon initial installation for any custom plan set-ups
- A billing fee may be added to each monthly Premium bill. The billing fee may include a fee for the recovery of any surcharges for amounts paid through credit card, debit card or other similar means.
- A reinstatement fee pursuant to the Termination provision.



- A conversion fee may be charged in connection with each employee or dependent electing conversion coverage. The conversion fee may be charged monthly based upon the number of covered persons electing conversion coverage during the previous month.
- A fee may be charged in connection with a check returned due to insufficient funds.

**Grace Period.** The Grace Period is the 31 consecutive day period immediately following the Premium Due Date granted for the payment of Premium and applicable fees, during which time the Policy will remain in force. If all Premiums and fees are not received before the end of the Grace Period, this Policy will be automatically terminated on the date the Grace Period expires.

We will mail a written notice to the Policyholder at least 10 days prior to the end of the grace period informing the Policyholder that the premium was not received and that the policy will be terminated as of the premium due date if the premium is not received by the end of the 31 day grace period.

**Payment of Premiums and Fees.** The Policyholder will pay premiums and fees in advance. They must be paid at Our home office or its authorized agent.

If the premiums and any fees are not paid by the Premium Due Date and before the end of the Grace Period, this policy will automatically terminate when the Grace Period ends. We will require the Policyholder to pay interest on the total premium amount and any fees overdue after the Premium Due Date including the premiums due for the Grace Period. The interest rate will be up to 1 1/2% per month for each month; or partial month; the balance remains unpaid. No interest will accrue during the Grace Period, however interest is payable on any unpaid amount still due once the Grace Period ends. We may recover from the Policyholder: costs of collecting any unpaid premiums or fees, including reasonable attorney's fees; and costs of suit.

(GR29N 05-03 01 TX)

**Changes in Premium.** We may also change the Premium rates effective as of any Premium Due Date upon 60 days prior written notice to the Policyholder. However, no such adjustment will be made during the Initial Term except to reflect changes in applicable law or regulation or a judicial decision having a material impact on the cost of providing Coverage.

**Retroactive Adjustments.** The Policyholder will pay premiums for each employee until the end of the month in which the Policyholder notifies Us that the employee is no longer part of the group eligible for coverage under the Policy. We may, at Our discretion, make retroactive adjustments to the Policyholder's billings for the termination of employees not posted to previous billings. However, the Policyholder may only receive a maximum of 2 month's credit for employee terminations that occurred more than 60 days before the date the Policyholder notified Us of the termination. We may reduce any such credits by the amount of any payments We may have made on behalf of such employees before We were informed their coverage had been terminated. Retroactive additions will be made at Our discretion based upon eligibility guidelines stated in the Certificate, and are subject to the payment of all applicable premiums.

(GR29N 05-03 01 TX)

**Premium Rate Reduction For Failure to Meet Performance Guarantees.** We may reduce the Policyholder's premium due to Our failure to provide the agreed upon levels of service. Such service levels are guaranteed by Us and agreed to in writing by Us and the Policyholder.

The reduction is based upon a percentage of the projected annual premium which is due over the term of the period for which service levels are guaranteed. The reduction amount will be credited, toward either future or prior premiums, at the end of the policy year.

The reduction will apply only to all coverages used under the plan issued under this policy.

The terms of the Performance Guarantees are set forth in the Service Agreement.

## Premiums and Fees (Continued)

**Schedule of Premiums and Fees.** The initial monthly Premium Rates are as follows:

Long Term	Per \$100 of	\$0.219
Disability	Covered	
Income	Monthly	
	Payroll	

## Responsibilities of the Policyholder (GR-29N 06-01 01)

**Records.** The Policyholder will furnish to Us, on a monthly basis (or as otherwise required), such information as We may reasonably require to administer this Policy. This information may be on our form (or such other form as We may reasonably approve) by facsimile (or such other means as We may reasonably approve). This includes, but is not limited to, information needed to enroll employees of the Policyholder, process terminations, and effect changes in family status and transfer of employment of employees.

The Policyholder represents that all enrollment and eligibility information that has been or will be supplied to Us is accurate. The Policyholder acknowledges that We can and will rely on such enrollment and eligibility information in determining whether a person is eligible for coverage under this Policy. To the extent such information is supplied to Us by the Policyholder (in electronic or hard copy format), the Policyholder agrees to:

- Maintain a reasonably complete record of such information (in electronic or hard copy format, including evidence of coverage elections, evidence of eligibility, changes to such elections and terminations) for at least seven years or until the final rights and duties under this Policy have been resolved, and to make such information available to Us upon request.
- If applicable, obtain from all employees a "Disclosure of Healthcare Information" authorization in the form currently being used by Us in the enrollment process (or such other form as We may reasonably approve).

We will not be liable to employees for the fulfillment of any obligation prior to information being received in a form satisfactory to Us. The Policyholder must notify Us of the date in which an employee's employment ceases for the purpose of termination of coverage under this Policy. Subject to applicable law, unless otherwise provided in the Certificate, We will consider an employee's employment to continue until stopped by the Policyholder.

The Policyholder must notify employees of the termination of the Policy in compliance with all applicable laws. However, We reserve the right to notify employees of termination of the Policy for any reason, including non-payment of premium. The Policyholder shall provide written notice to employees of their rights upon termination of coverage.

**Access.** Make payroll and other records directly related to an employee's coverage under this Policy available to Us for inspection, at Our expense, at the Policyholder's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of this Policy.

**Forms.** Distribute materials to employees regarding enrollment and coverage features. This includes coverage Certificates as described in the Certificates provision of the Policy section *General Provisions*.

**Policies and Procedures; Compliance Verification.** Comply with all policies and procedures established by Us in administering and interpreting this Policy. The Policyholder shall, upon request, provide a certification of its compliance with Our participation and contribution requirements. The Policyholder shall, upon request, submit proof that it continues to meet the definition of an eligible group as provided under applicable law or regulation.

**Continuation Rights and Conversion.** Notify all eligible employees and dependents of their right to continue coverage pursuant to the continuation provisions in the Certificate and applicable law; and provide employees a copy of the "Notice of Conversion Privilege and Request" form upon their request.

# Termination

**Termination by Policyholder.** This Policy, or any coverage included may be terminated by the Policyholder. The Policyholder may terminate this Policy as to all or any class of its employees. **Aetna** must be given written notice. The notice must state when such termination shall occur. It must be a date after the notice. It shall not be effective during a period for which a premium has been paid to Us for the coverage.

**Termination by Us.** This Policy will terminate as of the last day of the Grace Period if the Premium remains unpaid at the end of the Grace Period as described in the *Grace Period* provision under the *Premiums and Fees* section and is subject to the terms of any laws or regulations.

In addition, We may terminate this Policy as to any or all coverage, other than the Health Expense Coverage, of all or any class of employees or dependents of any one or more member employers by giving prior written notice to the Policyholder of when it will terminate. The date shall not be earlier than 31 days after the date of the notice unless it is agreed to by the Policyholder and Us.

As used in this section: "Health Expense Coverage" means:

- Comprehensive Medical Plan;
- Major Medical Plan;
- Prescription Drug Plan;
- Basic Hospital Plan;
- Basic Medical Plan;
- Limited Medical Plan; and
- Comprehensive Hearing Benefits

But does not include:

- Basic Dental Plan;
- Comprehensive Dental Plan;
- Comprehensive Vision Benefits; and
- DMO Dental

**This Policy may also be terminated by Us as follows:**

- Immediately upon notice to Policyholder if the Policyholder has performed any act or practice that constitutes fraud or made any intentional misrepresentation of a material fact relevant to the coverage provided under this Policy;
- Upon 30 days written notice to the Policyholder if the Policyholder breaches a provision of this Policy and such breach remains uncured at the end of the notice period;
- Upon 30 days written notice to the Policyholder if the Policyholder ceases to meet Our requirements for an employer group as defined under applicable state law or regulation;
- Upon 30 days written notice to the Policyholder if the Policyholder: (i) fails to meet Our contribution or participation requirements applicable to this Policy (which contribution and participation requirements are available upon request); (ii) fails to provide the certification required by the Policies and Procedures; *Compliance Verification* provision under Section 4 within a reasonable period of time specified by Us; or (iii) changes its eligibility or participation requirements without Our consent;
- Upon 90 days written notice to the Policyholder (or such shorter notice as may be permitted by applicable law, but in no event less than 30 days) if We cease to offer the product line to which the Policy relates;

### Termination By Us. (Continued)

- Upon 180 days written notice to the Policyholder (or such shorter notice as may be permitted by applicable law, but in no event less than 30 days) if We cease to offer coverage in a market in which persons covered under this Policy reside; or

If the Policy terminates for any reason, the Policyholder will continue to be held liable for all Premiums and fees due and unpaid before the termination, including, but not limited to, Premium payments for any period of time Policy is in force during the Grace Period. Covered persons shall also remain liable for their cost sharing and other required contributions to coverage for any period of time Policy is in force during the Grace Period. We may recover from the Policyholder Our costs of collecting any unpaid Premiums or fees, including reasonable attorneys' fees and costs of suit.

**Non-Renewal.** We may request from the Policyholder, a written indication of their intention to renew or non-renew a Policy at any time during the final three months of any policy year. If the Policyholder fails to reply to such request within two weeks of their receipt of the request; or 15 days prior to the renewal date, whichever is later; then upon **Aetna's** written notice to the Policyholder, all or a part of the Policy shall be deemed to terminate automatically as of the end of the policy year. Similarly, upon Our written confirmation to the Policyholder, We may accept an oral indication by the Policyholder; or its agent or broker of intent to non-renew as the Policyholder's notice of termination of all or a part of the Policy effective as of the end of the policy year.

**Effect of Termination.** No termination of this Policy will relieve either party from any obligation incurred before the date of termination. When terminated, this Policy and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. Upon termination, We will provide employees and their dependents with Certificates of Creditable Coverage which will show evidence of their prior health coverage under this Policy for a period of up to 18 months prior to the loss of coverage.

We may, at Our sole discretion, reinstate terminated coverage provided any past due premium and reinstatement fees are paid.

**Notice to employees.** It is the responsibility of the Policyholder to notify employees of the termination of the Policy in compliance with all applicable laws. However, We reserve the right to notify employees of termination of the Policy for any reason, including non-payment of Premium. In accordance with the Certificate, the Policyholder shall provide written notice to employees of their rights upon termination of coverage.

# General Provisions

**Policy.** The entire Policy consists of:

- This Policy;
- The application, copy attached;
- The current rates on file with the Policyholder;
- The attached Certificate(s); and
- Any riders, endorsements, inserts, attachments or amendments to this Policy or Certificate(s).

**Certificates.** Our method of providing the Policyholder with Certificates will be electronic. But We will provide a supply of paper copies to the Policyholder upon request. The Policyholder shall make available or distribute the Certificates to each insured employee. The insurance in force will be set forth in the Certificate. Statements as to whom benefits are payable will appear. Any applicable Conversion Privilege will also be described.

**Policies and Procedures.** We have the right to adopt reasonable policies, procedures, rules, and interpretations of this Policy and the Certificate in order to promote orderly and efficient administration.

**Policy Changes.** This Policy shall be deemed to be automatically amended to conform with the provisions of applicable laws and regulations. This Policy may also be amended by Us by written agreement between Us and the Policyholder.

The consent of any employee or other person is not needed. All agreements made by Us are signed by one of its executive officers. No other person can change or waive any of the Policy terms or make any agreement binding Us.

The Policyholder will not have to give written agreement of a change in the Policy if:

- The Policyholder has asked for the change and We have agreed to it.
- The change is needed to correct an error in the Policy, including any Certificate issued to anyone.
- The change is needed so that the Policy will conform to any law, regulation or ruling of a jurisdiction that affects a person covered under this Policy; or the federal government.
- The change has been initiated by Us and is not resulting in either: a reduction or elimination in benefits or coverage; or an increase in premium

The Policyholder will have to give written agreement of a change in the Policy:

- That reduces or eliminates benefits or coverage; or
- That increases benefits or coverage with a concurrent increase in premium during the Policy term, except if the increased benefits or coverage is required by law.

Payment of the applicable premium after notice of the proposed changes will be deemed to constitute the Policyholder's written agreement of those changes on behalf of all persons covered under this Policy.

**Prior Agreements; Severability.** As of the Effective Date, this Policy replaces and supersedes all other prior agreements between the Parties as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the Parties related to matters covered by this Policy or the documents incorporated herein. If any provision of this Policy is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this Policy shall continue in full force and effect.

**Clerical Errors.** A clerical error in keeping records; or a delay in making an entry; will not alone decide if insurance is valid. An equitable adjustment in premiums will be made when the error or delay is found. If the clerical error affects the existence or amount of insurance, the facts as determined by Us will be used to decide if insurance is in force and its amount. We may also modify or replace a Policy, Certificate or other document issued in error.

**Claim Determinations; ERISA Claim Fiduciary.** For the purpose of section 503 of Title 1 of the Employee Retirement Income Security Act of 1974, as amended (ERISA), We are a fiduciary with complete authority subject to Texas and Federal law, to review all denied claims for benefits under this Policy. This includes, but is not limited to, the denial of certification of the **medical necessity** of hospital or medical treatment. In exercising such fiduciary responsibility, We shall have discretionary authority to determine whether and to what extent eligible employees and beneficiaries are entitled to benefits and to construe any disputed or doubtful terms under this Policy, the Certificate or any other document incorporated herein. We shall be deemed to have properly exercised such authority unless We abuse our discretion by acting arbitrarily and capriciously. We have the right to adopt reasonable policies, procedures, rules, and interpretations of this Policy to promote orderly and efficient administration.

The Policyholder shall be responsible for making reports and disclosures required by ERISA. This includes the creation, the distribution, and the final content of:

- Summary plan descriptions;
- Summary of material modifications; and
- Summary annual reports.

Our review of claims may include the use of commercial software (including Claim Check) and other tools to take into account factors such as an individual's claims history, a Provider's billing patterns, complexity of the service or treatment, amount of time and degree of skill needed and the manner of billing.

**Misstatements.** If any intentional misstatement of material fact as to the Policyholder or any employee or dependent is found to have occurred, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the Policyholder or an employee shall be deemed representations and not warranties. No written statement made by an employee shall be used by Us in a contest unless a copy of the statement is or has been furnished to the employee or his beneficiary, or the person making the claim.

Our failure to implement or insist upon compliance with any provision of this Policy at any given time or times, shall not constitute a waiver of Our right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

*(GR-29N 09-03 01)*

**Incontestability.**

**As to Accident and Health Benefits.** Except as to an intentional misstatement of material fact, or issues concerning Premiums due:

- No statement made by the Policyholder or any employee or dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
- No statement made by the Policyholder shall be the basis for voiding this Policy after it has been in force for 2 years from its effective date.
- No statement made by an eligible employee or dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

**Physical Exam or Autopsy.** Aetna may conduct a physical examination of an individual for whom a claim is made when and as often as Aetna reasonably requires during the pendency of the claim under the policy.



**Assignability.** Except for benefits provided by the plan for health care services to providers, no rights or benefits under this Policy are assignable by the Policyholder to any other party unless approved by Us.

**Waiver.** Our failure to implement, or insist upon compliance with, any provision of this Policy or the terms of the Certificate incorporated hereunder, at any given time or times, shall not constitute a waiver of Our right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of Premiums or benefits. This applies whether or not the circumstances are the same.

**Notices.** Any notice required or permitted under this Policy shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the face page of the Policy, or to any more recent address of which the sending party has received written notice or, if delivered by facsimile or other electronic means, on the date sent by facsimile or other electronic means.

**Third Parties.** This Policy shall not confer any rights or obligations on third parties except as specifically provided herein.

**Non-Discrimination.** In the management of this Policy, the Policyholder and the Member Employers:

- Will make no attempt, whether through differential contributions or otherwise, to encourage or discourage enrollment in the coverages provided by the Policy based on health status or health risk; and
- Will act so as not to discriminate unfairly between persons in like situations at the time of the action.
- Will make no distinction on the basis of the marital status or lack of marital status between an insured and the other parent in the determination of the dependents or the beneficiaries of the insured, or both.

We can rely on such action and will not have to probe into the details.

**Use of Our Name and all Symbols, Trademarks, and Service Marks.** We reserve the right to control the use of Our name and all symbols, trademarks, and service marks presently existing or subsequently established. The Policyholder agrees that it will not use such name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without Our prior written consent and will cease any and all usage immediately upon Our request or upon termination of this Policy.

**Workers' Compensation.** The Policyholder is responsible for protecting Our interests in any Workers' Compensation claims or settlements with any eligible individual. We shall be reimbursed for all paid medical expenses which have occurred as a result of any work related **injury** that is compensable or settled in any manner.

On or before the Effective Date of this Policy and upon renewal, the Policyholder shall submit proof of their Workers' Compensation coverage or an exclusion form which has been accepted by the applicable regulatory authority governing Workers' Compensation. Upon Our request, the Policyholder shall also submit a monthly report to Us listing all Workers' Compensation cases. Such list will contain the name, social security number, date of loss and diagnosis of all applicable eligible individuals.

**Reporting of Claims.** All claims should be reported promptly. The deadline for filing a claim is 20 days after the date of the loss. Failure to give notice within the time prescribed above does not invalidate or reduce any claim if it is shown that it was not reasonably possible to give the notice within that time and that notice was given as soon as was reasonably possible.

**Payment of Claims.** All benefits payable under the policy will be paid not later than the 60th day after the date the proof of loss is received. All benefits are payable to the insured or the insured's assignee.

# Schedule of Benefits

(GR-29N 01-01 01 TX)

**Employer:** Dell Inc.

**Group Policy Number:** GP-476626

**Issue Date:** January 1, 2009

**Effective Date:** January 1, 2009

**Schedule:** 1A

**Cert Base:** 1

For: Long Term Disability

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

# Long Term Disability Coverage (GR-29N 05-01 01 TX)

## Schedule of Long Term Disability Benefits

### Elimination Period

The first 180 days of a period of disability.

(GR-29N 05-01 01 TX)

### Scheduled Monthly Benefit

60% of your monthly **predisability earnings**

(GR-29N 05-01 01 TX)

Maximum Monthly Benefit Under this Plan (plus all other Income benefits)

\$10,000

### Minimum Monthly Benefit

(GR-29N 05-01 01 TX)

The greater of:

- (a) \$100; and
- (b) 10% of your scheduled monthly benefit or, if less, 10% of the maximum monthly benefit

## Evidence Requirements

Refer to your Booklet-Certificate for information about when you will be required to submit evidence of good health and what your responsibilities are to complete and submit this information to **Aetna**.

## Benefits Actually Payable

Any monthly benefit actually payable to you by **Aetna** will be reduced by other Income benefits. For additional information regarding other income benefits, see your Booklet Certificate.

## Maximum Benefit Duration\*

If your period of disability starts prior to your 61st birthday, it will end the last day of the calendar month in which you reach age 65.

If your period of disability starts on or after your 61st birthday, it will end with the expiration of the number of months of disability, after the elimination period is met, based on the following schedule:

### Maximum Benefit Duration Schedule

#### Age When Period of Disability Starts

#### Months of Disability

61 but less than 62	48 months
62 but less than 63	42 months
63 but less than 64	36 months
64 but less than 65	30 months
65 but less than 66	24 months
66 but less than 67	21 months
67 but less than 68	18 months
68 but less than 69	15 months
69 and over	12 months

\*Unless your disability ends earlier for one or more of the reasons stated in your Booklet-Certificate.

## General (GR-9N S-28-01 01)

This *Schedule of Benefits* replaces any similar *Schedule of Benefits* previously in effect under your plan of long term disability benefits. Requests for coverage other than that to which you are entitled in accordance with this *Schedule of Benefits* cannot be accepted. This Schedule is part of your Booklet-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.

# BENEFIT PLAN

**Prepared Exclusively for  
Dell Inc.**

**Long Term Disability**

**What Your Plan  
Covers and How  
Benefits are Paid**

**Aetna Life Insurance Company  
Booklet-Certificate**

This Booklet-Certificate is part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder



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\* Defines the Terms Shown in Bold Type in the Text of This Document.

## Preface (GR-9N-02-005-02 TX)

Aetna Life Insurance Company (ALIC) is pleased to provide you with this *Booklet-Certificate*. Read this *Booklet-Certificate* carefully. The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as **Aetna**).

This *Booklet-Certificate* is part of the *Group Insurance Policy* between Aetna Life Insurance Company and the Policyholder. The *Group Insurance Policy* determines the terms and conditions of coverage. **Aetna** agrees with the Policyholder to provide coverage in accordance with the conditions, rights, and privileges as set forth in this *Booklet-Certificate*. The Policyholder selects the products and benefit levels under the plan. A person covered under this plan and their covered dependents are subject to all the conditions and provisions of the *Group Insurance Policy*.

The *Booklet-Certificate* describes the rights and obligations of you and **Aetna**, what the plan covers and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet-Certificate*. Your *Booklet-Certificate* includes the *Schedule of Benefits* and any amendments or riders.

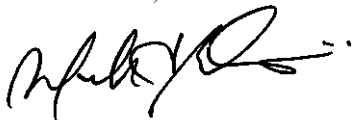
If you become insured, this *Booklet-Certificate* becomes your *Certificate of Coverage* under the *Group Insurance Policy*, and it replaces and supersedes all certificates describing similar coverage that **Aetna** previously issued to you.

Group Policyholder: Dell Inc.  
Group Policy Number: GP-476626  
Effective Date: July 18, 2011  
Issue Date: July 25, 2011  
Booklet-Certificate Number: 1

**THE GROUP INSURANCE POLICY UNDER WHICH THIS BOOKLET-CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

**THIS CERTIFICATE IS GOVERNED BY APPLICABLE FEDERAL LAW AND THE LAWS OF TEXAS.**

(GR-9N-02-005-01 TX)



Mark T. Bertolini  
Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

**IMPORTANT NOTICE**

To obtain information or make a complaint:

You may call Aetna's toll-free telephone number for information or to make a complaint at

1-800- 694-3258

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714-9104  
FAX No. (512) 475-1771

**Premium or Claim Disputes:**

Should you have a dispute concerning your premium or about a claim you should contact Aetna first. If the dispute is not resolved you may contact the Texas Department of Insurance.

**Notice:**

This notice is for information only and does not become a part or condition of your Policy.

**AVISO IMPORTANTE**

Para obtener información o para someter una queja:

Usted puede llamar al numero de telefono gratis de (company)'s para informacion o para someter una queja al

1-800- 694-3258

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos, o quejas llamando al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714-9104  
FAX No. (512) 475-1771

**Disputas Sobre Primas o Reclamaciones:**

Si surge una disputa concerniente a su prima o a una reclamación, debe comunicarse con Aetna primero. Si no se resuelve la disputa puede comunicarse con el Departamento de Seguros de Texas.

**Aviso:**

Este aviso es sólo para propósito de información y no se convierte en una parte o condición de su Póliza.

## Important Information Regarding Availability of Coverage (GR-9N 02-005 02)

No benefits are covered under this *Booklet-Certificate* in the absence of payment of current premiums subject to the *Grace Period* and the *Premium* section of the *Group Insurance Policy*.

Unless specifically provided in any applicable termination provision described in this *Booklet-Certificate* or under the terms of the *Group Insurance Policy*, the plan does not pay benefits for a disability that starts before coverage starts under this plan. This plan will also not pay any benefits for any disability that starts after coverage ends.

Benefits may be modified during the term of this plan as specifically provided under the terms of the *Group Insurance Policy* or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any disabilities that start on or after the effective date of the plan modification. There is no vested right to receive the benefits described in the *Group Insurance Policy* or in this *Booklet-Certificate* if the disability starts on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.



# Coverage for You

## Long Term Disability Coverage

The plan may pay to you a portion of your income earnings as a monthly benefit for a period of long term disability caused by an **illness** or **injury** that occurs while your coverage is in effect.

Coverage under this plan is occupational and non-occupational. **Occupational injuries and illnesses** and **non-occupational injuries illnesses** are covered. Conditions that are related to pregnancy may be covered under this plan.

Please refer to the *Long Term Disability* section for more details about your coverage.

# Eligibility, Enrollment and Effective Date of Your Coverage

(GR-9N 29-005-02-TX-LG-L)

Who Can Be Covered

How and When to Enroll

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you", "your" and "yours" means the employee to whom this *Booklet-Certificate* is issued and whose insurance is in force under the terms of this group insurance policy.

## Who Can Be Covered

Your employer determines the criteria that are used to define the eligible class for coverage under this plan. Such criteria are based solely upon the conditions related to your employment. **Aetna** will rely upon the representation of the employer as to your eligibility for coverage under this plan and as to any fact concerning such eligibility.

### Employees

You are eligible for coverage under this plan if you are **actively at work** and:

- You are in an eligible class, as defined below;
- You have completed any probationary period required by the policyholder; and
- You have reached your eligibility date.

### Determining if You Are in an Eligible Class (GR-9N 29-005-02)

You are in an eligible class if:

- You are a regular full-time employee, as defined by your employer.

In addition, to be in an eligible class you must be:

- scheduled to work on a regular basis at least 25 hours per week during your Employer's work week; and
- working within the United States or Canada.

### Probationary Period (GR-9N 29-005-02)

Once you enter an eligible class, you will need to complete the probationary period before your coverage under this plan begins.

### Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows.

### On the Effective Date of the Plan

If you are in an eligible class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

### After the Effective Date of the Plan

If you are hired or enter an eligible class after the effective date of this plan, your coverage eligibility date is the date you complete 30 days of continuous service with your employer. This is defined as the probationary period. If you had already satisfied the plan's probationary period before you entered the eligible class, your coverage eligibility date is the date you enter the eligible class.

## How and When to Enroll (GR-9N 29-015-02)

### Enrollment

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by **Aetna** and your employer. To complete the enrollment process, you will need to provide all requested information including any evidence of good health. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, and will advise you of the required amount. Your contributions will be deducted from your pay. Remember plan contributions are subject to change.

Your contributions may be reduced due to Aetna's failure to provide agreed upon service levels. Such service levels are guaranteed by Aetna and agreed to in writing by Aetna and your Employer. See your employer for details.

You will need to enroll within 31 days of your eligibility date.

### Evidence of Good Health (GR-9N 29-015-02)

You must provide evidence of good health that is satisfactory to **Aetna** if:

- You request to enroll more than 31 days after your eligibility date.
- You request to reinstate coverage that ended because you voluntarily stopped your coverage or you did not make the required contributions.
- You had prior coverage with another carrier.

If you are required to submit evidence of good health, you must furnish all such evidence at your own expense.

## When Your Coverage Begins (GR-9N 29-015-02) (GR-9N 29-025-02)

### Your Effective Date of Coverage

If you have met all the eligibility requirements, your coverage takes effect on the later of:

- The date you are eligible for coverage; or
- The date you return your completed enrollment information; and
- Your application is received and approved in writing by **Aetna**; and
- The date your required contribution is received by **Aetna**.

### Important Notice:

You must pay the required contribution in full.

### Active Work Rule:

If you happen to be ill or injured and away from work on the date your coverage would take effect, the coverage will not take effect until you return to active full-time work for one full day.

This rule also applies to an increase in your coverage.

# Your Disability Plan

(GR-9N 06-005 02) (GR-9N 06-010 02)

Benefit Eligibility

Benefits Payable

Successive Disabilities

## Important Note

As used in this section of the *Booklet-Certificate*, "you" and "your" refers to a covered employee of the employer sponsoring this plan.

The disability plan provides you with a source of income if you should become disabled because of an illness, **injury** or disabling pregnancy-related condition while covered under this plan.

## Long Term Disability (LTD) Coverage

Long term disability (LTD) coverage will pay a monthly benefit if you are disabled and unable to work because of:

- An **illness**;
- An **injury**; or
- A disabling pregnancy-related condition.

## Long Term Disability Benefit Eligibility

You will be considered disabled while covered under this Long Term Disability (LTD) Plan on the first day that you are disabled as a direct result of a significant change in your physical or mental conditions and you meet all of the following requirements:

- You must be covered by the plan at the time you become disabled; and
- You must be under the regular care of a **physician**. You will be considered under the care of a **physician** up to 31 days before you have been seen and treated in person by a **physician** for the **illness, injury** or pregnancy-related condition that caused the disability; and
- You must be disabled by the **illness, injury**, or disabling pregnancy-related condition as determined by **Aetna** (see *Test of Disability*); and
- You have been disabled for a consecutive period of 180 calendar days or total of 180 calendar days in a rolling 12 month period, whichever occurs earlier.

GR-9N 06-005 476626-1 TX 0711

## When Benefits Are Payable

Once you meet the LTD **test of disability**, your long term disability benefits will be payable after the Elimination Period, if any, is over. No benefit is payable for or during the Elimination Period. The Elimination Period is the amount of time you must be disabled before benefits start. The Elimination Period is shown in the *Schedule of Benefits*.

Your Long Term Disability benefits will be payable for as long as your period of disability benefit eligibility continues but not beyond the end of the Maximum Monthly Benefit Period. The Elimination Period and the Maximum Monthly Benefit Period are shown in the *Schedule of Benefits*.

## Premium and Contribution Waiver

During your disability while benefits are payable:

- You will not have to make any further contributions.
- No premium payments will be required from your Employer.

## Premium/Contribution Reinstatement

If you are eligible to continue coverage, your contributions and the employer's premium payments may be resumed on the first due date following the end of a period of disability during which premiums and contributions were waived.

## Test of Disability (GR-9N 06-010 02)

From the date that you first became disabled and until monthly benefits are payable for 24 months you meet the test of disability on any day that:

- You cannot perform the **material duties** of your **own occupation** solely because of an **illness, injury** or disabling pregnancy-related condition; and
- Your earnings are 80% or less of your **adjusted predisability earnings**.

**After the first 24 months of your disability** that monthly benefits are payable, you meet the plan's test of disability on any day you are unable to work at any **reasonable occupation** solely because of an **illness, injury** or disabling pregnancy-related condition.

### Important Note

The loss of a professional or occupational license or certification that is required by your **own occupation** does not mean you meet the test of disability. You must meet the plan's test of disability to be considered disabled.

## Benefits Payable (GR-9N 06-015 02)

Benefits are paid on a monthly basis. The benefit amount is based on your **predisability earnings**, up to the maximum monthly benefit shown in the *Schedule of Benefits*.

To calculate your monthly long term disability benefit, multiply:

- Your Monthly **predisability earnings**; times
- The Benefit Percentage shown in the *Schedule of Benefits*.

The LTD benefit payable will be the lesser of:

- The monthly LTD benefit; and
- The maximum monthly benefit.

Any other income benefits you are eligible for may affect your benefits from this plan. The amount of the other income benefits will be subtracted from your monthly LTD benefit for which you are eligible. If the result is less than the minimum monthly benefit shown in the *Schedule of Benefits*, the plan will pay an amount equal to the minimum monthly benefit. Please refer to the *Other Income Benefits* section of this Booklet-Certificate for details as to which other income benefits may reduce your monthly LTD benefit.

## Adjustments to Your Benefits If You Work While Disabled (GR-9N 06-020 02)

Your long term disability monthly benefit may be reduced if, while monthly benefits are payable, you receive income from:

- Your employer or any other employer, employment or self-employment; or
- Any occupation for compensation or profit;

which is more than 20% of your **adjusted predisability earnings**. The monthly benefit adjustment is calculated as follows:

During the first 12 months that you have such income, the benefit will be reduced only to the extent the sum of the amount of that income and the monthly benefit payable, without any reduction for other income benefits, exceeds 100% of your **adjusted predisability earnings**.

Thereafter,

The adjusted monthly benefit will be calculated by using the following formula:

(A divided by B), times C, where:

A = Your **adjusted predisability earnings**, minus the income you receive while disabled

B = Your **adjusted predisability earnings**

C = The monthly benefit payable.

Income means income you earn, while disabled and working, from your employer or any other employer. However, any income earned by working for another employer will be considered income only if you:

- Become employed after the date your disability started; or
- Increase the number of hours you work, or the number or type of duties you perform for another employer after the date of your disability started. In that event, only the amount of the income increase will be taken into consideration for the benefit adjustment.

### **When Long Term Disability Benefit Eligibility Ends** (GR-9N 06-025 01)

You will no longer be considered as disabled nor eligible for long term monthly benefits when the first of the following occurs:

- The date you no longer meet the LTD test of disability, as determined by **Aetna**.
- The date you are no longer under the regular care of a **physician**.
- The date **Aetna** finds you have withheld information about working, or being able to work, at a **reasonable occupation**.
- The date you fail to provide proof that you meet the LTD test of disability.
- The date you refused to be examined by or cooperate with an independent **physician** or a licensed and certified health care practitioner, as requested. **Aetna** has the right to examine and evaluate any person who is the basis of your claim at any reasonable time while your claim is pending or payable. The examination or evaluation will be done at **Aetna's** expense.
- The date an independent medical exam report or functional capacity evaluation does not, in **Aetna's** opinion, confirm that you are disabled.
- The date you reach the end of your Maximum Benefit Duration, as shown in the *Schedule of Benefits*.
- The date you are not receiving **effective treatment for alcoholism or drug abuse**, if your disability is caused (in whole or part) by alcoholism or drug abuse.
- The date you refuse to cooperate with or accept:
  - Changes to your work site or job process designed to suit your identified medical limitations; or
  - Adaptive equipment or devices designed to suit your identified medical limitations; which would allow you to work at your **own occupation** or a **reasonable occupation** (if you are receiving benefits for being unable to work any **reasonable occupation**) and provided that a **physician** agrees that such changes, adaptive devices or equipment suit your particular medical limitations.

- The date you refuse any treatment recommended by your attending **physician** that, in **Aetna's** opinion, would cure, correct or limit your disability.
- The date your condition would permit you to:
  - Work; or
  - Increase the hours you work; or
  - Increase the number or type of duties you perform in your **own occupation** but you refuse to do so.
- The date of your death.
- The day after **Aetna** determines that you can participate in an **approved rehabilitation program** and you refuse to do so.

### **Limitations Which Apply to Long Term Disability Coverage** (GR-9N 06-030 01)

You will no longer be considered as disabled and eligible for long term monthly benefits after benefits have been payable for 24 months if it is determined that your disability is primarily caused by:

- A mental health or psychiatric condition, including physical manifestations of these conditions, but excluding conditions with demonstrable, structural brain damage; or
- Alcohol and/or drug abuse.

There are 2 exceptions to the above limitations if you are confined as an inpatient in a **hospital or treatment facility** for treatment of that condition at the end of such 24 months.

- If the inpatient confinement lasts less than 30 days, the disability will cease when you are no longer confined.
- If the inpatient confinement lasts 30 days or more, the disability may continue until 90 days after the date you have not been so continuously confined.

#### **Important Note**

The rules under *If You Become Disabled Again* do not apply beyond 24 months to disabilities subject to this *Limitations Which Apply to Long Term Disability Coverage* section.

### **If You Become Disabled Again (Successive Disabilities)**

Once you are no longer disabled and your monthly benefit payments have ended, any new disabilities will be treated separately. However, 2 or more separate disabilities due to the same or related causes will be deemed to be one disability and only one Elimination Period will apply if your disability occurs again within 6 months or less of continuous **active work** from when the prior disability ended.

**Aetna** will resume its payments to you if your coverage has remained continuously in effect for the period of your temporary recovery. You will not need to satisfy a new Elimination Period.

If:

- Your disability ended;
- Benefits were not payable because you did not meet the elimination period; and
- Your disability due to the same or related cause occurs again after less than 30 days of continuous active work from when the prior disability ended;

you will only need to satisfy the remainder of the elimination period in order to be considered eligible for benefits payments.

The first disability will not be included if it began while you were not covered under this LTD plan.

If you become eligible for coverage under any other group long term disability benefits plan carried or sponsored by your employer, this *If You Become Disabled Again* section will no longer apply to you.

## Pre-existing Conditions

A pre-existing condition is an **illness, injury** or pregnancy-related condition for which, during the 3 months before your coverage or increase in coverage became effective:

- You were diagnosed or treated; or
- You received diagnostic or treatment services; or
- You took drugs that were prescribed or recommended by a **physician**.

The plan does not pay benefits for a disability that is caused, or contributed to, by a pre-existing condition, if the disability starts within the first 12 months after your coverage goes into effect.

## Special Rules As To An Increase in Coverage

If your disability is caused by a pre-existing condition, your monthly benefit will be based on the amount of the Scheduled monthly benefit that has been in effect for at least 3 months under this plan or any other prior coverage. You will not be eligible for any benefit increase if the disability starts within the first 12 months after you increase in coverage goes into effect.

## Approved Rehabilitation Program (GR-9N 06-050-01)

**Aetna** has the right to evaluate you for participation in an **approved rehabilitation program**.

If, in **Aetna's** judgment, you are able to participate, **Aetna** may, in its sole discretion require you to participate in an **approved rehabilitation program**.

The plan will pay for all of the services and supplies, approved in advance by **Aetna**, you need in connection with participation in the program, except those for which you can be reimbursed by another payer, including government benefits programs.

During your active participation in an **Aetna approved rehabilitation program**, **Aetna** will increase the monthly benefit payable. A 10% increase in the monthly benefit payable (after all applicable reductions for other income benefits) will be paid for up to six consecutive months for each disability, up to a maximum monthly increase of \$500.

## Other Income Benefits (GR-9N 06-055-02) (GR-9N 06-060 01)

### Important Note

Please read this section carefully. It explains how and when other income benefits reduce your monthly LTD benefit. ***It is your responsibility to enroll or apply for benefits from other sources if you are eligible.*** See the *Aetna Requires Proof of Other Income* section for more information.

Other income benefits can affect the monthly benefit described in the long term disability coverage section. When calculating the benefit payable, other income benefits that you, your spouse, your children or your dependents are eligible for because of your disability or retirement are taken into consideration.

The other income benefits considered when your benefits payable are calculated are:

- 50% of any award given under The Jones Act or The Maritime Doctrine of Maintenance, Wages and Cure.
- Disability, retirement or unemployment benefits required or provided for by government law. This includes (but is not limited to):
  - Unemployment compensation benefits.
  - Temporary or permanent, partial or total, disability benefits under any workers' compensation law or similar law meant to compensate a worker for:
    - Loss of past and future wages;
    - Impaired earning capacity;



- A lessened ability to compete for jobs;
- Any permanent impairment; and
- Any loss of bodily function or capacity.
- Automobile no-fault wage replacement benefits required by law.
- Benefits under the Federal Society Security Act, Railroad Retirement Act, Canada Pension Plan and Quebec Pension Plan.
- Veteran's benefits.
- Statutory disability benefits
- Disability or unemployment benefits payable by either insured and uninsured plans:
  - As a result of employment by or association with your employer; or
  - As a result of your membership in, or association with, any group, association, union or other organization.

This includes both plans that are insured and those that are not.

- Unreduced retirement benefits for which you are (or may become) eligible under a group pension plan at age 62 or the plan's normal retirement age, whichever comes later. This applies only to the amount of the benefit that was paid by an employer.
- Retirement benefits you elect and receive under any group pension plan. This applies only to the amount of the benefit that was paid by an employer.
- Disability benefits from an accumulated sick time or salary continuation program, provided they are part of an established group plan maintained by your Employer for the benefit of its employees.

### **What Happens When Other Income Benefits Increase** (GR-9N 06-070-01)

An increase in other income benefits that you are eligible for may affect your benefit payable under this coverage.

If your other income benefits increase as the result of one of the following situations, the increased amount will be considered when calculating your benefits payable:

- The number of people in your family changes;
- Your benefit level is adjusted or corrected; or
- The severity of your disability changes.

This may result in a reduction in benefits payable.

A cost of living increase in other income benefits you receive from a governmental source (including, but not limited, to benefits under the Federal Social Security Act) will not reduce your benefits payable.

A cost of living increase in other income benefits you receive from a non-governmental source will **not** affect your benefits payable to the extent that the increase is based on the annual average increase in the **Consumer Price Index**.

### **How Aetna Applies Other Income Benefits** (GR-9N 06-075 02)

#### **Long Term Disability**

Any Lump sum or periodic payments you receive from any other income benefit are prorated on a monthly basis over the period of time for which the payment was made. If a period of time is not indicated, **Aetna** will prorate the payments over a reasonable period of time. **Aetna** will take into account the expected duration of your disability payments and other relevant factors.

The part of a lump sum or periodic payment you receive for disability will be counted as an other income benefit, even if it is not specifically allotted or identified as such. If there is no proof acceptable to **Aetna** as to what that part is, **Aetna** will consider 50% to be payable for your disability.

Any of these other income benefit payments that date back to a prior date may be allocated on a retroactive basis. If the other income benefits are automobile no-fault wage replacement benefits or disability payments which result from a disability caused by a third party, the applicable period of time will start from the date of the accident.

### **Estimate of Other Income Benefits**

**Aetna** will estimate other income benefits for which you appear to be eligible, unless you sign and return a reimbursement agreement to **Aetna**. The reimbursement agreement includes your promise to repay **Aetna** for any overpayment of benefits made to you as a result of your receipt of other income benefits. If other income benefits are estimated, your monthly benefit will be adjusted when **Aetna** receives proof:

- Of the exact amount paid or awarded; or
- That benefits have been denied after review at the highest administrative level.

If estimating your other income benefits results in an underpayment, **Aetna** will pay you the difference between the underpayment and the benefit payable. If there is an overpayment, you must repay **Aetna** the difference between all overpayments and the benefit payable. If **Aetna** must take legal action to recover such overpayment, you also must pay **Aetna's** reasonable attorneys fees and court costs, if **Aetna** prevails.

### **Aetna Requires Proof of Other Income** (GR-9N-06-080 01)

**Aetna** may require proof:

- That you, your spouse, child or dependent has applied for all other income benefits that you or they are or may be eligible to receive because of your disability, and has made a timely appeal of any denial of benefits through the highest administrative level. "Timely appeal" means making the appeal in the time required, but never more than 60 days after the latest denial.
- That the person applying for other income benefits has furnished the necessary proof needed to obtain other income benefits, which include, but is not limited to, workers' compensation benefits;
- That the person has not waived (given up his or her right to) any other income benefits without **Aetna's** written consent;
- That the person has sent **Aetna** copies of documents showing the effective dates and amounts of other income benefits.
- Of income you receive from any work for pay or profit.

If you apply for Social Security benefits and are denied, you must request reconsideration within 60 days after the denial unless **Aetna** states, in writing, that you are not required to do so. If the reconsideration is denied, you must apply for a hearing before an administrative law judge within 60 days of the denial, unless **Aetna** waives this requirement.

You do not have to apply for:

- Retirement benefits paid only on a reduced basis; or
- Disability benefits under a group life insurance plan, if the disability benefits would reduce the amount of your group life insurance.

However, if you apply for and receive these benefits, they will be considered as other income benefits and you must provide proof to **Aetna**, if requested.

If you do not provide the proof that **Aetna** may require, **Aetna** has the right to suspend or adjust this plan's benefits by the estimated amount of the other income benefits.

## How Prior Coverage Affects Coverage Under This Plan

If the coverage of any person under this plan replaces any prior coverage of the person, the following will apply.

"Prior Coverage" is any plan of group LTD coverage that has been replaced by coverage under part or all of this plan.

It must have been sponsored by your Employer who is participating in this plan. The replacement can be complete or in part for the eligible class to which you belong. Any such plan is prior coverage if provided by another group insurance plan.

Your coverage under this Plan replaces and supersedes any prior coverage. It will be in exchange for everything under such prior coverage, except that no benefit will be payable under this plan as to a particular period of disability if:

- You are receiving, or eligible to receive, benefits for that disability under the prior coverage; or
- In the absence of coverage under this plan, you would have been eligible to receive benefits for that disability under the prior coverage.

### Same or Related Causes of Disability

Any disability that began before you were covered under this LTD plan will not be included for purposes of the *If You Become Disabled Again (Successive Disabilities)* section of this plan. However, if extent it would have applied under the terms of the prior coverage had it remained in force:

- You had prior coverage on the day before LTD coverage took effect; and
- You became covered for this LTD plan on the date it takes effect; and
- While you are insured under this plan, a disability starts that is due to the same **illness, injury** or disabling pregnancy related condition for which you received or were eligible to receive benefits under the prior coverage; and
- There are no benefits available under the terms of the prior coverage for this disability due to the same **illness, injury** or disabling pregnancy related condition, the Elimination Period under this plan will apply to the extent it would have applied under the terms of the prior coverage had it remained in force.

Where the above paragraph applies, the amount of monthly benefit and the maximum period for which benefits will be payable, as to a disability due to the same or related causes, will be as provided in this LTD plan.

### Pre-existing Conditions

As stated earlier, no benefits will be payable, as to a disability caused by a pre-existing condition. However if:

- You had prior coverage on the day before LTD coverage took effect; and
- You became covered for this LTD plan on the date it takes effect;

a benefit may be payable if a continuous period of coverage under the prior coverage and this LTD plan are equal to the lesser of:

- 24 months and;
- Any period of limitation as to a pre-existing condition remaining under the prior coverage.

Where the exclusion no longer applies, the amount of monthly benefit and the maximum period for which benefits will be payable, as to a disability caused by such pre-existing condition, will be as provided in this LTD plan, subject to the *Special Rules As To An Increase in Coverage* section.

In no event will:

- A benefit be payable as to a disability caused by a pre-existing condition, if the disability is excluded by any other terms of this LTD plan.
- A condition will be considered to be a pre-existing condition under this LTD plan if it was not a pre-existing condition under the prior coverage.

### **Survivor Benefit** (GR-9N 06-090 01)

If you die while disabled, a single, lump sum benefit will be paid under this provision if:

- There is an eligible survivor as defined below; and
- A monthly benefit was payable under this plan.

The benefit amount will be 3 times the monthly benefit, not reduced by other income benefits, for which you were eligible in the full month just before the month in which you die.

If you die before you are eligible for one full monthly benefit, however, the benefit will be 3 times the monthly benefit, not reduced by other income benefits for which you would have been eligible if you had not died, for the first full month after the month in which you die.

An eligible survivor is:

- Your legally married spouse at the date of your death.
- If there is no such spouse, your biological or legally adopted child who, when you die:
  - is not married; and
  - is depending on you for support; and
  - is under age 25. This age limit will not apply if the child is not capable of self-sustaining employment because of mental or physical handicap which existed prior to age 25.

### **How the Survivor Benefit Will Be Paid**

The benefit will be paid to your eligible surviving spouse, if any. Otherwise, it will be paid in equal shares to your eligible surviving children.

If monthly benefit payments are made in amounts greater than the monthly benefits that you are entitled to receive, **Aetna** has the right to first apply the survivor benefit to any such overpayment.

**Aetna** may pay the benefit to anyone who, in **Aetna's** opinion, is caring for and supporting the eligible survivor; or if proper claim is made, **Aetna** may pay the benefit to an eligible survivor's legally appointed guardian or committee.

### **Exclusions That Apply to Long Term Disability** (GR-9N 28-010-01)

Long term disability coverage does not cover any disability on any day that you are confined in a penal or correctional institution for conviction of a criminal act or other public offense. You will not be considered to be disabled, and no benefits will be payable.

Long term disability coverage also does not cover any disability that:

- Is due to insurrection, rebellion, or taking part in a riot or civil commotion.
- Is due to intentionally self-inflicted **injury** (while sane or insane).
- Is due to war or any act of war (declared or not declared).
- Results from your commission of, or attempting to commit a criminal act.

- Results from a motor vehicle accident caused by operating the vehicle while you are under the influence of alcohol. A motor vehicle accident will be deemed to be caused by the use of alcohol if it is determined that at the time of the accident you were :
- Operating the motor vehicle while under the influence of alcohol at a level which meets or exceeds the level at which intoxication would be presumed under the laws of the state where the accident occurred. If the accident occurs outside of the United States, intoxication will be presumed if the person's blood alcohol level meets or exceeds .08 grams per deciliter.

## When Coverage Ends

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

### When Coverage Ends For Employees (GR-9N 30-005 02 TX)

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- Your employment stops for any reason, including job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, your coverage may continue until stopped by your employer as described below:
  - Your Employer will notify Aetna of the date your coverage ceases for the purposes of termination of coverage under this Plan. Unless otherwise specified below, your official end of coverage date will be the end of the month in which you are no longer eligible under the plan.

For the purposes of this section, “month” means the period from a date in a calendar month to the corresponding date in the succeeding calendar month. If the succeeding calendar month does not have a corresponding date, the period ends on the last day of the succeeding calendar month.

Examples:

- For calendar months with succeeding corresponding dates: May 5th to June 5th would equal one “month”.
- For calendar months without succeeding corresponding dates: January 31st to February 28th would equal one “month”.
- The monthly premium required by Aetna for each person's coverage will be the applicable rate in effect on the date your coverage ends. Your Employer will be billed for the amount of your premium owed until the end of the month in which you are no longer eligible under the plan.
- If you are not **actively at work** due to **illness or injury**, your coverage may continue, until stopped by your employer, but not beyond 12 months from the start of the absence. If you are not **actively at work** due to temporary lay-off or leave of absence, your coverage will stop on the last day of the month following the month of your last full day of active work before the start of the lay-off or leave of absence.

It is your employer’s responsibility to let **Aetna** know when your employment ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.

## Reinstating Coverage (GR-9N 5-30-005-02 TX)

If your long term disability coverage ends, you may reinstate coverage subject to the rules described in the *When your Coverage Begins* section.

However, if your coverage ends because you stop active work, you may reinstate coverage without having to complete a new eligibility probationary period, if you return to active work in an *Eligible Class* within 24 months for the date your coverage ended.

In addition, if you return to work in an Eligible Class within 6 months of the date your coverage ended, the pre-existing condition rule applies to the extent the rule would have applied if your coverage had not ended.

For the above exceptions to apply, you must request to reinstate coverage within 31 days of your return to active work.

## Extension of Benefits (GR-9N 31-020 01 TX)

### Coverage for Long Term Disability Benefits

If your long term disability coverage ends during a period of total disability which began while you had coverage, any long term disability benefits will be continued until your benefit eligibility ends.

## General Provisions (GR-9N-32-005-02-TX)

### Physical Examinations and Evaluations

**Aetna** will have the right and opportunity to have a **physician** of its choice examine any person who is requesting certification or benefits for new and ongoing claims. Multiple exams, evaluations and functional capacity exams may be required during your disability for an ongoing claim. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

### Legal Action

No legal action can be brought to recover payment under any benefit after 2 years from the final decision date of your last appeal decision, but not later than 3 years from the date your eligibility for disability benefit was first denied.

**Aetna** will not try to reduce or deny a benefit payment on the grounds that a condition existed before your coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

## Additional Provisions

The following additional provisions apply to your coverage:

- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. Additional provisions are described elsewhere in the *group policy*. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or **Aetna**.
- Your employer hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.

## Assignments

Coverage may be assigned only with the written consent of **Aetna**.

## Misstatements

If any fact as to the Policyholder or you is found to have been an intentional misstatement of material fact, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the Policyholder or you shall be deemed representations and not warranties. No written statement made by you shall be used by **Aetna** in a contest unless a copy of the statement is or has been furnished to you or your beneficiary, or the person making the claim.

**Aetna's** failure to implement or insist upon compliance with any provision of this policy at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

With regard to intentional misstatements of a covered person's age, if the misstatement affects the existence or amount of coverage, the covered person's true age will be used in determining an equitable adjustment of premiums or benefits, or both.

## Incontestability

During the first two years that your insurance is in force, any statement, you have made in writing on a form signed by you that you have made may be used by **Aetna** in contesting the validity of that coverage. This also applies to any increase in your coverage for the two years that follow the effective date of that increase, if evidence of good health was required in order for the increase to take effect.

Once coverage (including any increases in coverage) has been continuously in effect for two years, the validity of your insurance (or increase in coverage) under this plan shall not be contested by **Aetna** unless your statement was in writing on a form signed by you and was fraudulently made in order to obtain that coverage or increase.

**Aetna** may also contest the validity of your insurance at any time under this plan for non-payment of premiums when due.



# Recovery of Overpayments (GR-9N-32-010-01)

## Long Term Disability Coverage

If payments are made in amounts greater than the benefits that you are entitled to receive, **Aetna** has the right to do any one or all of the following:

- Require you to return the overpayment on request;
- Stop payment of benefits until the overpayment is recovered;
- Take any legal action needed to recover the overpayment; and
- Place a lien, if not prohibited by law, in the amount of the overpayment on the proceeds of any other income, whether on a periodic or lump sum basis.

If the overpayment:

- Occurs as a result of your receipt of "other income benefits" for the same period for which you have received a benefit under this plan; and
- To obtain such "other income benefits", advocate or legal fees were incurred;

**Aetna** will exclude from the amount to be recovered, such advocate or legal fees; provided you return the overpayment to **Aetna** within 30 days of **Aetna's** written request for the overpayment. If you do not return the overpayment to **Aetna** within such 30 days, such fees will not be excluded; you will remain responsible for repayment of the total overpaid amount.

Examples of "other income benefits" are:

- Workers' compensation.
- Federal Social Security benefits.
- Disability payments made as a result of any person's action or inaction.

## Reporting of Claims (GR-9N-32-020-01-TX-EX-L)

You are required to submit a claim to **Aetna** in writing. Claim forms may be obtained from **Aetna**. Follow the procedure chosen by your Employer to report a disability claim to **Aetna**. If the procedure requires that claim forms be submitted, you may obtain them from your employer or **Aetna**.

Your claim must give proof of the nature and extent of the loss. You must furnish true and correct information as **Aetna** may reasonably request. At any time, **Aetna** may require copies of documents to support your claim, including data about employment. You must also provide **Aetna** with authorizations to allow it to investigate your claim and your eligibility for and the amount of work earnings and other income benefits.

You may also contact **Aetna** for claim forms. If the forms for a proof of loss are not provided before the 16th day after the date **Aetna** has received notice of a claim under the policy, the person making the claim is considered to have complied with the requirements of the policy as to proof of loss on submitting, within the time set in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

In addition to the above: if you must be out of work because you are disabled, a claim for a Long Term Disability Benefit should be made right away. Do not wait until you go back to work. This may delay payment of benefits. At any time, **Aetna** may require copies of documents to support your claim, including data about employment and any other income benefits.

The deadline for filing a long term disability claim is 90 days after the end of the elimination period, if any.



If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than one year after the deadline.

## **Payment of Benefits** (GR-9N 32-025 01 TX)

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

Long Term Disability benefits will be paid at the end of each calendar month during the period for which benefits are payable. Long Term Disability benefits for a period less than a month will be prorated. This will be done on the basis of the ratio, to 30 days, of the days of eligibility for benefits during the month.

Any unpaid balance (at the end of **Aetna's** liability as to Long Term Disability) will be paid within 30 days of receipt by **Aetna** of the due written proof.

## **Contract Not a Substitute for Workers' Compensation Insurance**

(GR-9N-32-030-01)

The group policy is not in lieu of and does not affect workers' compensation benefits. However, any workers' compensation benefits are considered other income benefits.

## **Contacting Aetna**

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna's** Home Office at:

Aetna Life Insurance Company  
151 Farmington Avenue  
Hartford, CT 06156

You may visit **Aetna's** web site at [www.aetna.com](http://www.aetna.com).

# Glossary<sup>\*</sup>

(GR-9N 34-005 01)

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet-Certificate.

## A (GR-9N 34-005 01 TX) (GR-9N 34-005 01-TX)

### **Active at Work; Actively at Work; Active Work** (GR-9N 34-005 01-TX)

You will be considered to be active at work, actively at work or performing active work on any of your employer's scheduled work days if, on that day, you are performing the regular duties of your job on a full time basis hours you are normally scheduled to work. In addition, you will be considered to be actively at work on the following days:

- any day which is not one of your employer's scheduled work days if you were actively at work on the preceding scheduled work day; or
- a normal vacation day.

### **Adjusted Predisability Earnings**

Your **predisability earnings**, plus any increase made on each January 1. The first increase will be made on the January 1 following a 12-month period of disability. On each January 1, the increase made will equal the percentage increase in the **Consumer Price Index**, rounded to the nearest tenth; to a maximum of 10%.

## **Aetna**

**Aetna** Life Insurance Company.

### **Approved Rehabilitation Program**

A written program, approved by **Aetna**, that provides for services and supplies which are intended to enable you to return to work. The program may include, but is not limited to:

- Vocational testing;
- Vocational training;
- Alternative treatment plans such as:
  - Support groups;
  - Physical therapy;
  - Occupational therapy; and
  - Speech therapy;
- Workplace modification to the extent not otherwise provided;
- Part time employment; and
- Job placement.

A rehabilitation program will no longer be an **approved rehabilitation program** on the date **Aetna** withdraws, in writing, its approval of the program.

## **E** (GR-9N 34-025 01 TX)

### **Effective Treatment of Alcoholism or Drug Abuse**

This means a program of alcoholism or substance abuse therapy that is prescribed and supervised by a **physician** and either:

- Has a follow-up therapy program directed by a **physician** on at least a monthly basis; or
- Includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

**Detoxification** and **maintenance care** are not effective treatment.

## **H** (GR-9N 34-040 02)

### **Hospital**

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

**In no event** does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

## **I** (GR-9N 34-045 02)

### **Illness** (GR-9N 34-045 02)

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

### **Injury**

An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

## **M** (GR-9N 34-065 02)

## Material Duties

Duties that:

- Are normally required for the performance of your **own occupation**; and
- Cannot be reasonably omitted or modified. However, to be at work in excess of 40 hours per week is not a material duty.

**O** (GR-9N 34-065 01 TX) (GR-9N 34-075 01 TX)

## Own Occupation

The occupation that you are routinely performing when your period of disability begins. Your occupation will be viewed as it is normally performed in the national economy instead of how it is performed:

- For your specific employer; or
- At your location or work site; and
- Without regard to your specific reporting relationship.

**P** (GR-9N 34-080 01 TX) (GR-9N 34-070 01 TX)

## Physician

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate; and
- Under applicable insurance law is considered a "physician" for purposes of this coverage.

For the purposes of Long Term Disability coverage, regular care of a physician means you are attended by a physician who:

- Is not you or related to you;
- Has the medical training and clinical expertise suitable to treat your disabling condition;
- Specializes in psychiatry, if your disability is caused, to any extent, by a mental health or psychiatric condition; and
- Whose treatment is:
  - Consistent with the diagnosis of the disabling condition;
  - According to guidelines established by medical, research and rehabilitative organizations; and
  - Administered as often as needed.

## Predisability Earnings

The amount of salary or wages you were receiving from an employer participating in this Plan on the day before a period of disability started, calculated on a monthly basis.

Your **predisability earnings** will be figured based on your Base Monthly Earnings.

“Base monthly earnings” means your “Daily Earnings” multiplied by 365 (366 for any year that is a leap year); then divided by 12. “Daily Earnings” means your annual base salary on the date you are certified as disabled by Aetna; divided by 365 (or 366, as applicable).

Included in salary or wages are:

- Sales commissions received as part of your total compensation will be included in your “Daily Earnings,” and your total targeted compensation will be divided by 365 (366 for any leap year). Total targeted compensation is the combination of your annual base salary (as defined above) plus your annual target sales incentive; each of which will be determined on your date of disability as determined above. Your annual targeted sales incentive does not include the actual commissions earned, sales bonuses earned, or monies earned as a result of sale promotions or contests.
- Contributions you make through a salary reduction agreement with your Employer to any of the following:
  - An Internal Revenue Code (IRC) Section 125 plan for your fringe benefits.
  - An IRC 401(k), 403(b), or 457 deferred compensation arrangement.
  - An executive nonqualified deferred compensation agreement.

Salary or wages do not include:

- Awards and bonuses.
- Overtime pay.
- Fringe benefits.
- Shift Differential.
- Profit Sharing.
- Contributions made by your Employer to any deferred compensation arrangement or pension plan.
- Extra compensation such as payments for revenue sharing, housing allowances, stipends, relocation incentives or buyouts of unused vacations, professional fees, non qualified income.
- Any other special pay or compensation.

A retroactive change in your rate of earnings will not result in a retroactive change in coverage.

## **R** (GR-9N 34-090 02)

### **Reasonable Occupation**

This is any gainful activity:

- For which you are, or may reasonable become, fitted by education, training, or experience; and
- Which results in, or can be expected to result in, an income of more than 80% of your **adjusted predisability earnings**.

## **T** (GR-9N 34-095 01 TX) (GR-9N 34-100 02)

### **Treatment Facility**

This is an institution (or distinct part thereof) that is for the treatment of alcoholism or drug abuse and which meets fully every one of the following tests:

- It is primarily engaged in providing on a full-time inpatient basis, a program for diagnosis, evaluation, and treatment of alcoholism or drug abuse.
- It provides all medical detoxification services on the premises, 24 hours a day.

- It provides all normal infirmity-level medical services required during the treatment period, whether or not related to the alcoholism or drug abuse, on a 24 hour daily basis. Also, it provides, or has an agreement with a **hospital** in the area to provide, any other medical services that may be required during the treatment period.
- On a continuous 24 hour daily basis, it is under the supervision of a staff of **physicians**, and provides skilled nursing services by licensed nursing personnel under the direction of a full-time registered graduate nurse.
- It prepares and maintains a written individual plan of treatment for each patient based on a diagnostic assessment of the patient's medical, psychological and social needs with documentation that the plan is under the supervision of a **physician**.
- It meets any applicable licensing standards established by the jurisdiction in which it is located.

### Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law.

Some of the ways in which personal information is used include claim payment; utilization review and management; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Information Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call 1-866-825-6944 or visit our Internet site at [www.aetna.com](http://www.aetna.com).

## Additional Information Provided by

Dell Inc.

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

**Employer Identification Number:**

REDACTED

**Plan Number:**

501

**Type of Plan:**

Welfare

**Type of Administration:**

Group Insurance Policy with:

Aetna Life Insurance Company  
151 Farmington Avenue  
Hartford, CT 06156

**Plan Administrator:**

One Dell Way  
MS RR 8042  
Round Rock, TX 78682

**Agent For Service of Legal Process:**

One Dell Way  
MS RR 8042  
Round Rock, TX 78682

**End of Plan Year:**

December 31

**Source of Contributions:**

Employer and Employee

**Procedure for Amending the Plan:**

The Employer may amend the Plan from time to time by a written instrument signed by Tre McCalister.

**ERISA Rights**

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

### **Receive Information about Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.



### **Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law**

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave) in accordance with FMLA, your Employer may allow you to continue coverage for which you are covered under the group contract on the day before the approved FMLA leave starts. This includes any long term disability coverage for which you are covered under the group contract even though the group contract does not provide for continuation of long term disability coverage during a leave of absence. However, if a period of disability starts while you are on an approved FMLA leave, the waiting period for such period of disability will not be deemed to end until the later of:

- the date you complete the waiting period; and
- the date you are scheduled to return to active work following the approved FMLA leave.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

# Aetna Life Insurance Company

Hartford, Connecticut 06156

## **Amendment** (GR-9N-Appeals 01-01 01 TX)

<b>Policyholder</b>	Dell Inc.
<b>Group Policy No.</b>	GP-476626
<b>Rider</b>	Complaint and Appeals Disability Rider
<b>Issue Date</b>	January 1, 2009
<b>Effective Date</b>	January 1, 2009

## **Appeals Disability Coverage**

The group policy specified above has been amended. The following summarizes the changes in the group policy, and the Certificate of Insurance describing the policy terms is amended accordingly. This amendment is effective on the date shown above.

## **Complaint and Appeals Procedure**

### **Definitions**

**Adverse Benefit Determination:** A denial; termination of; or failure to provide or make payment (in whole or in part) for a benefit.

Such **adverse benefit determination** may be based on your eligibility for coverage.

**Appeal:** A written request to Aetna to reconsider an **adverse benefit determination**.

## **Filing Disability Claims under the Plan**

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

## **Claim Determinations - Group Disability Income Coverage**

Aetna will make notification of a claim determination as soon as possible but not later than 45 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 45 calendar days claim determination period is required. Such an extension, of not longer than 30 additional calendar days, will be allowed if Aetna notifies you within the first 45 calendar days period. If prior to the end of the first 30 calendar days extension period, Aetna again determines that due to matters beyond its control a decision cannot be made within that extension period, the claim determination period may be extended for an additional 30 calendar days. Aetna must notify you, prior to the end of the first extension period, of the circumstance requiring the extension and the date by which a decision can be expected.

The notice of any extension, by Aetna, for any Disability Income Coverage, shall specifically explain:

- the standards on which entitlement to a benefit is based;
- the unresolved issues that prevent a decision on the claim; and
- the additional information needed to resolve those issues.

The claimant will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

## Appeals of Adverse Benefit Determinations

You may submit an **appeal** if Aetna gives notice of an **adverse benefit determination**. If you choose, another person (an authorized representative) may make the appeal on your behalf by providing written consent to Aetna.

Your **appeal** may be submitted orally or in writing and should include:

- Your name;
- Your employer's name;
- A copy of Aetna's notice of an **adverse benefit determination**;
- Your reasons for making the **appeal**; and
- Any other information you would like to have considered.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

Send in your **appeal** to the address shown on the notice of **adverse benefit determination** or you may call in your **appeal** using the toll-free telephone number listed on such notice.

Aetna will acknowledge receipt, in writing, of your appeal within 5 working days of receiving it.

## Appeal – Group Disability Income Claims

Aetna shall issue a decision within 45 calendar days of receipt of the request for an **appeal**. If Aetna determines that due to special circumstances an extension of time for claim processing is required, such an extension, of not longer than 45 additional calendar days, will be allowed if Aetna notifies you within the first 45 calendar day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which a decision can be expected.

# Aetna Life Insurance Company

Hartford, Connecticut 06156

## Rider for Covered Persons in the State of Texas (GR-9N-CR1)

**Policyholder** Dell Inc.  
**Group Policy No** 476626  
**Effective Date** October 1, 2012

The group policy specified above has been modified by this Rider. The following summarizes the changes in the group policy, and the Certificate of Insurance describing the policy terms is modified accordingly. This Rider is effective on the date shown above and applies only to covered persons in the state of Texas.

**1. The following section titled Other Income Benefits replaces the section with the same name in your current Booklet-Certificate:**

### Other Income Benefits (GR-9N 06-055-02) (GR-9N 06-060 01)

#### Important Note

Please read this section carefully. It explains how and when other income benefits reduce your monthly LTD benefit. ***It is your responsibility to enroll or apply for benefits from other sources if you are eligible.*** See the *Aetna Requires Proof of Other Income* section for more information.

Other income benefits can affect the monthly benefit described in the long term disability coverage section. When calculating the benefit payable, other income benefits that you, your spouse, your children or your dependents are eligible for because of your disability or retirement are taken into consideration.

The other income benefits considered when your benefits payable are calculated are:

- 50% of any award given under The Jones Act or The Maritime Doctrine of Maintenance, Wages and Cure.
- Disability, retirement or unemployment benefits required or provided for by government law. This includes (but is not limited to):
  - Unemployment compensation benefits.
  - Temporary or permanent, partial or total, disability benefits under any workers' compensation law or similar law meant to compensate a worker for:
    - Loss of past and future wages;
    - Impaired earning capacity;
    - A lessened ability to compete for jobs;
    - Any permanent impairment; and
    - Any loss of bodily function or capacity.
  - Automobile no-fault wage replacement benefits required by law.
  - Benefits under the Federal Society Security Act, Railroad Retirement Act, Canada Pension Plan and Quebec Pension Plan.
  - Veteran's benefits.
- Statutory disability benefits
- Disability or unemployment benefits payable by either insured and uninsured plans:
  - As a result of employment by or association with your employer; or
  - As a result of your membership in, or association with, any group, association, union or other organization.

This includes both plans that are insured and those that are not.

- Unreduced retirement benefits for which you are (or may become) eligible under a group pension plan at age 62 or the plan's normal retirement age, whichever comes later. This applies only to the amount of the benefit that was paid by an employer.
- Retirement benefits you elect and receive under any group pension plan. This applies only to the amount of the benefit that was paid by an employer.
- Disability payments from under insured motorist (UIM), uninsured motorist coverage (UM), liability insurance or other sources for a disability caused by a third party. "Other sources" include (but are not limited to) damages or a settlement received through legal action.
- Disability benefits from an accumulated sick time or salary continuation program, provided they are part of an established group plan maintained by your Employer for the benefit of its employees.

2. The following section titled **Recovery of Overpayments** replaces the section with the same name in your current Booklet-Certificate.

## Recovery of Overpayments (GR-9N-32-010-01)

### Long Term Disability Coverage

If payments are made in amounts greater than the benefits that you are entitled to receive, **Aetna** has the right to do any one or all of the following:

- Require you to return the overpayment on request;
- Stop payment of benefits until the overpayment is recovered;
- Take any legal action needed to recover the overpayment; and
- Place a lien, if not prohibited by law, in the amount of the overpayment on the proceeds of any other income, whether on a periodic or lump sum basis.

If the overpayment:

- Occurs as a result of your receipt of "other income benefits" for the same period for which you have received a benefit under this plan; and
- To obtain such "other income benefits", advocate or legal fees were incurred;

This Plan will exclude from the amount to be recovered, such advocate or legal fees; provided you return the overpayment to **the plan** within 30 days of **the plan's** written request for the overpayment. If you do not return the overpayment to this plan within such 30 days, such fees will not be excluded; you will remain responsible for repayment of the total overpaid amount.

Examples of "other income benefits" are:

- Workers' compensation.
- Federal Social Security benefits.
- Disability payments made by, or on behalf of, a third party as a result of any person's action or inaction.



Mark T. Bertolini  
Chairman, Chief Executive Officer and President  
Aetna Life Insurance Company  
(A Stock Company)

03  
Texas Rider: Long Term Disability  
Issue Date: January 14, 2013

# Aetna Life Insurance Company

Hartford, Connecticut 06156

**Rider for Covered Persons in the State of Texas** (GR-9N-CR1)

**Policyholder** Dell Inc.  
**Group Policy No** 476626  
**Effective Date** January 1, 2014

The group policy specified above has been modified by this Rider. The following summarizes the changes in the group policy, and the Certificate of Insurance describing the policy terms is modified accordingly. This Rider is effective on the date shown above and applies only to covered persons in the state of Texas.

**1. The following section titled When Benefits Are Payable replaces the section with the same name in your current Booklet-Certificate:**

## **When Benefits Are Payable**

Once you meet the LTD **test of disability**, your long term disability benefits will be payable after the Elimination Period, if any, is over. No benefit is payable for or during the Elimination Period. The Elimination Period is the amount of time you must be disabled before benefits start. The Elimination Period is shown in the *Schedule of Benefits*.

Your Long Term Disability benefits will be payable for as long as your period of disability benefit eligibility continues but not beyond the end of the Maximum Monthly Benefit Period. The Elimination Period and the Maximum Monthly Benefit Period are shown in the *Schedule of Benefits*. However, if you are outside the **home area** when benefits would otherwise be payable, no more than twelve Monthly Benefit payments will be made, subject to any Maximum Benefit Amount.

## **Home Area**

The United States of America, the Dominion of Canada, the Commonwealth of Puerto Rico, Guam, and the Virgin Islands of the United States.



Mark T. Bertolini  
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

Texas Rider: 4  
Issue Date: April 21, 2014

**Aetna Life Insurance Company**  
**Hartford, Connecticut 06156**

**Rider for Covered Persons in the State of Texas** *(GR-9N-CR1)*

**Policyholder** Dell Inc.  
**Group Policy No** 476626  
**Effective Date** July 11, 2014

The group policy specified above has been modified by this Rider. The following summarizes the changes in the group policy, and the Certificate of Insurance describing the policy terms is modified accordingly. This Rider is effective on the date shown above and applies only to covered persons in the state of Texas.

**The section on the following page titled Determining if You Are in an Eligible Class replaces the section with the same name in your current Booklet-Certificate:**



Mark T. Bertolini  
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

Texas Rider: 6 - Long Term Disability  
Issue Date: July 14, 2014



## **Determining if You Are in an Eligible Class**

You are in an eligible class if you are a regular full-time employee, as defined by your employer.

In addition, to be in an eligible class you must be:

- scheduled to work on a regular basis at least 25 hours per week during your Employer's work week; and
- working within the United States; or
- working outside the United States on international assignment for an unlimited number of years.

# Aetna Life Insurance Company

## Hartford, Connecticut 06156

### Rider for Covered Persons in the State of Texas (GR-9N-CR1)

**Policyholder:** Dell Inc.  
**Group Policy No.:** GP-476626  
**Effective Date:** November 1, 2014

The group policy specified above has been modified by this Rider. The following summarizes the changes in the group policy, and the Certificate of Insurance describing the policy terms is modified accordingly. This Rider is effective on the date shown above and applies only to covered persons in the state of Texas.

The following section entitled Survivor Benefit replaces the section with the same title in your current Booklet-Certificate.

### Survivor Benefit (GR-9N 06-090 01)

If you die while disabled, a single, lump sum benefit will be paid under this provision if:

- There is an eligible survivor as defined below; and
- A monthly benefit was payable under this plan.

The benefit amount will be 3 times the monthly benefit, not reduced by other income benefits, for which you were eligible in the full month just before the month in which you die.

If you die before you are eligible for one full monthly benefit, however, the benefit will be 3 times the monthly benefit, not reduced by other income benefits for which you would have been eligible if you had not died, for the first full month after the month in which you die.

An eligible survivor is:

- Your legally married spouse at the date of your death.
- Your sole domestic partner.
- If there is no such spouse or domestic partner, your biological or legally adopted child who, when you die:
  - is not married; and
  - is depending on you for support; and
  - is under age 25. This age limit will not apply if the child is not capable of self-sustaining employment because of mental or physical handicap which existed prior to age 25.

A domestic partner will be determined to be an eligible survivor if you have completed and signed a "Declaration of Domestic Partnership", and the Declaration is acceptable to your Employer.

A domestic partner will no longer be considered to be an eligible survivor as the date of termination of the domestic partnership. In that event, you should provide your Employer with a completed and signed "Declaration of Termination of Domestic Partnership".

### How the Survivor Benefit Will Be Paid

The benefit will be paid to your eligible surviving spouse or domestic partner, if any. Otherwise, it will be paid in equal shares to your eligible surviving children.

If monthly benefit payments are made in amounts greater than the monthly benefits that you are entitled to receive, **Aetna** has the right to first apply the survivor benefit to any such overpayment.

**Aetna** may pay the benefit to anyone who, in **Aetna's** opinion, is caring for and supporting the eligible survivor; or if proper claim is made, **Aetna** may pay the benefit to an eligible survivor's legally appointed guardian or committee.



Mark T. Bertolini  
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

Long Term Disability for Full-Time Dell Hourly & Salaried Employees  
Texas Rider: 7  
Issue Date: December 4, 2014